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The Official Publication of the Podiatry-Chiropody Profession

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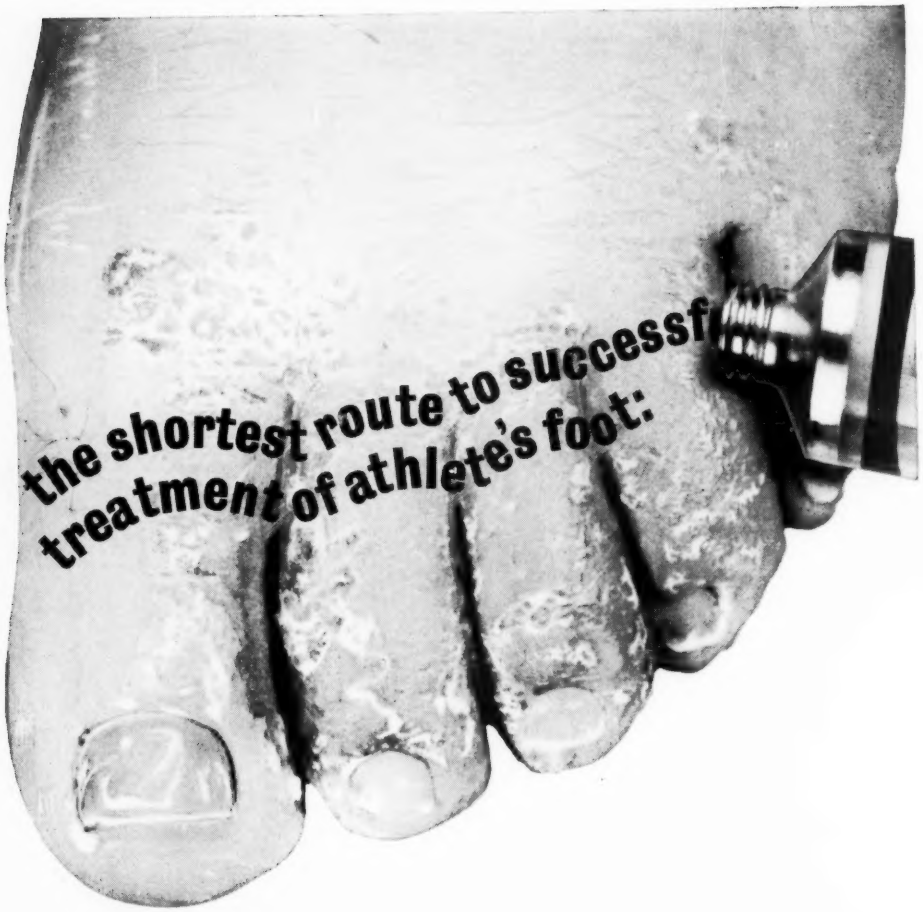

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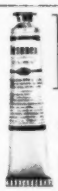

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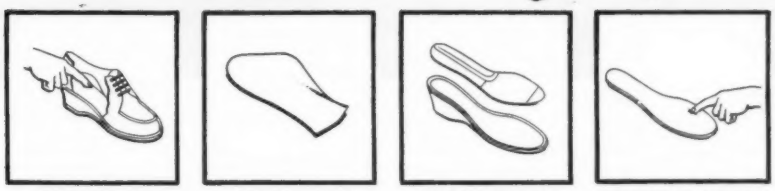

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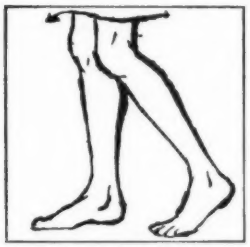
SIMPLE OFFICE TEST* EXPEDITES TREATMENT

Palpating pedal pulsation at rest.

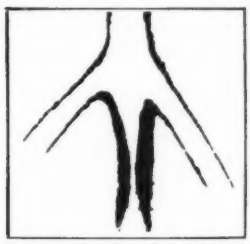
A recent report* shows that peripheral arteriosclerosis as a cause of intermittent claudication is frequently overlooked because early in the disease the patient may have adequate pedal pulses if he is examined only at rest.

In 13 patients with fatigue, aching or severe leg cramps, all of whom had readily palpable pedal pulses at rest, DeWeese* demonstrated disappearance of these pulses following sufficient exercise to bring on pain. In his test, patients ran in place at 140 to 160 steps a minute until claudication occurred. A possible explanation of this phenomenon "...is based on the shunting of the insufficient blood supply to smaller, vasodilated arteries so that weakened pulsations are observed in the larger arteries."*



Exercising patient prior to postexercise palpation of pulses.

Based on his findings, DeWeese recommends "...that an exercise test be performed on any patient with symptoms suggestive of intermittent claudication who has palpable pedal pulses [at rest], before obstructive atherosclerosis is ruled out as a cause of the symptoms."*



Postexercise shunting of blood into dilated collaterals.

Awareness of this phenomenon, with routine performance of the exercise test, will undoubtedly help increase early diagnosis of peripheral vascular disease. Consequently, treatment can be instituted sooner, improving the likelihood of a favorable response to therapy.

*DeWeese, J. A.: New England J. Med. *262*:1214-1217 (June 16) 1960.

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References: (1) Samuels, S. S., and Shaftel, H. E.: J.A.M.A. *171*:142-144 (Sept. 12) 1959. (2) Kaindl, F.; Samuels, S. S.; Selman, D., and Shaftel, H.: Angiology *10*:185-192 (Aug.) 1959. (3) Clarkson, I. S., and Le Fere, D. M.: Angiology *11*:190-192 (June) 1960.

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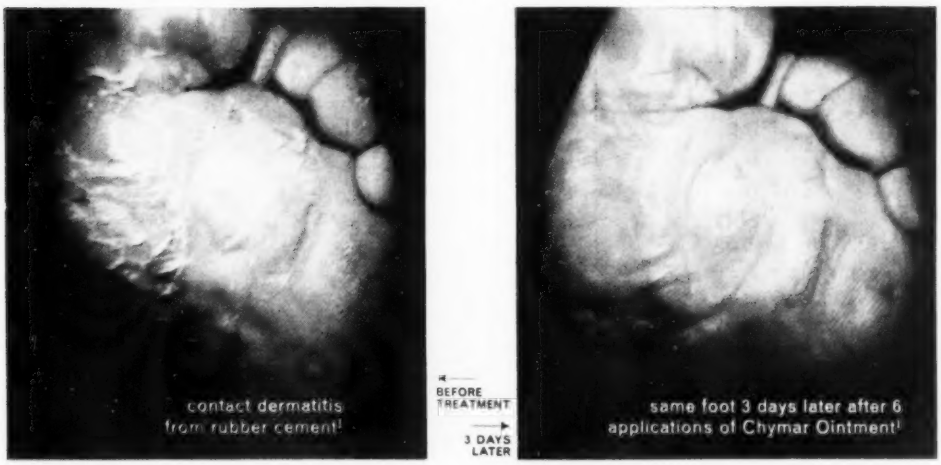
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1. Walker, M. H.: The Therapeutic Use of a Corticosteroid-Antibiotic-Enzyme Ointment in Common Foot Lesions, to be published. 2. Lucas, R. D.: Current Podiatry (March) 1960. 3. Streiker, F. B.: The Use of Chymotrypsin in Foot Orthopedics. Paper Presented at the Annual Meeting, American Podiatry Association, Chicago, Illinois, August, 1960.

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*Combes, F. C.: Ind. Med. & Surg. 30:29-34 (Jan.) 1961.

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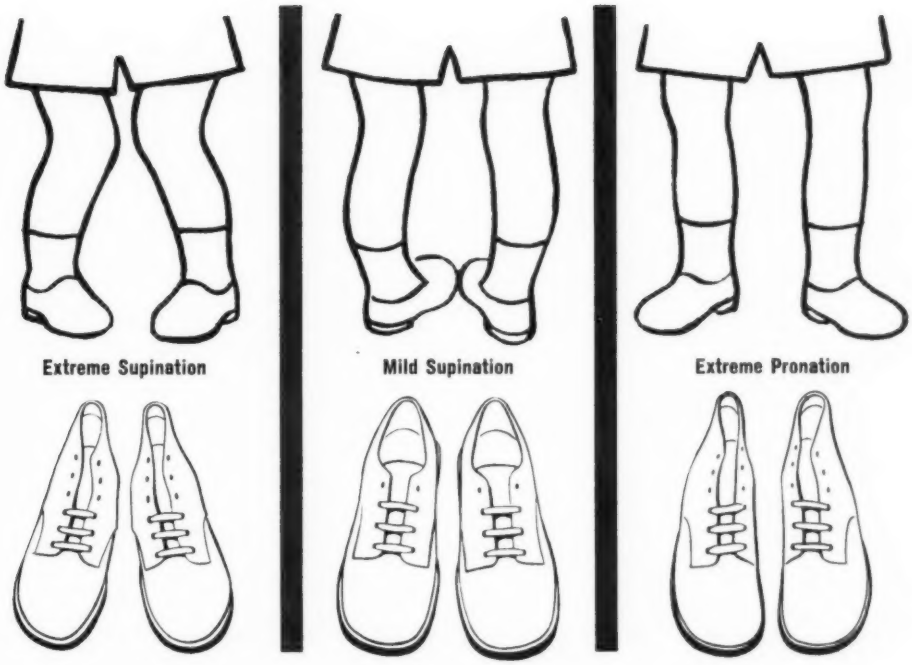

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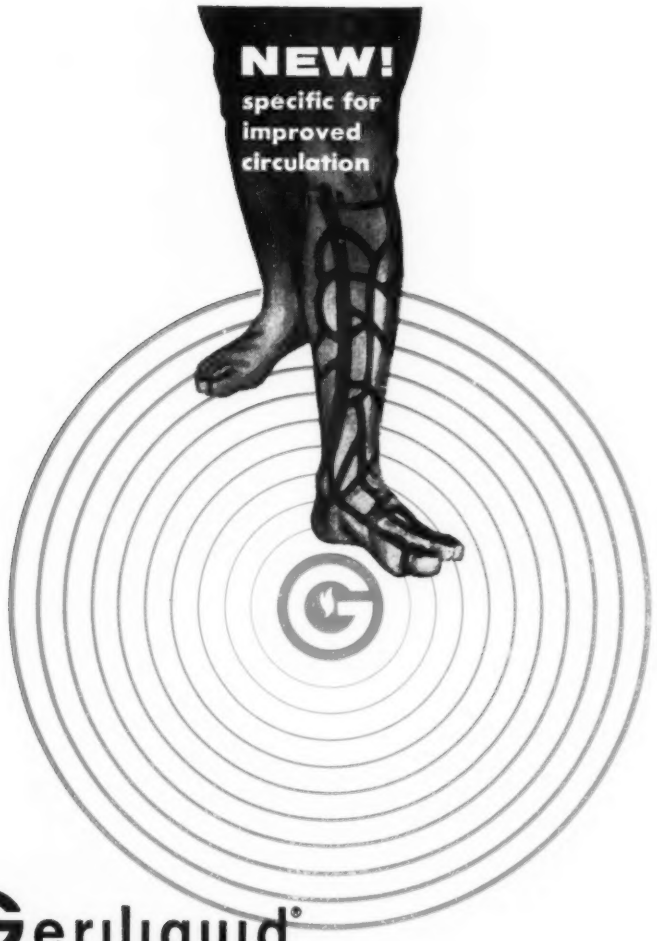

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North Dakota Association of Podiatrists	T. W. Cockrell, Five Kemper Block, Minot, N. Dak. Martha Kilander, P. O. Box 1805, Minot, N. Dak.
Ohio Chiropodists Association	Wallace L. Beylin, 1755 W. Market St., Akron 13, Ohio Lon H. Cooper, 346-352 Ohio Bldg., Sidney, Ohio J. E. Farmer (Ex. Sec.), Fifty W. Broad St., Columbus, Ohio
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Oregon Podiatry Association, Inc.	George McCauley, 4126 N. E. Broadway, Portland, Ore. William V. Wheeler, 405 High St., N. E., Salem, Ore.
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Virginia, Podiatry Society of	Herman Chapel, New Monroe Bldg., Norfolk, Va. I. Leonard Kaplan, 718 Court St., Portsmouth, Va.
Washington State Podiatry Association	Heber H. Routh, 511 Fidelity Bldg., Spokane, Wash. Robert H. Armstrong, 409 General Insurance Bldg., Seattle 5, Wash.
West Virginia, Podiatry Society of	W. C. Baber, 204 Union Bank Bldg., Clarksburg, W. Va. G. A. Taylor, 1st Huntington Natl. Bank Bldg., Huntington, W. Va.
Wisconsin State Podiatry	Eugene V. Hurtienne, 2705 North 8th St., Sheboygan, Wis. Michel M. Addis, Med. Arts Bldg., 945 N. 12 St., Milwaukee 3, Wis.
Wyoming Podiatry Society	L. A. Catellier, 215 W. 18th St., Cheyenne, Wyo. Duane NeuSchultz, 2201 West A, Torrington, Wyo.

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American College of Foot Roentgenologists, Louis P. Zulli, 1436 S. Broad St., Philadelphia 46, Pa.
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American Board of Chiropodical Dermatology—Joy E. Adams, Florida National Bank Bldg., St. Petersburg, Fla.

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American Association of Colleges of Chiropody—Leroy C. Numbers, 1327 N. Clark St., Chicago 10, Ill.
National Board of Chiropody Examiners—M. H. Gennis, 1432 So. Peoria Ave., Tulsa, Okla.
American Academy of Chiropodists—Robert Smith, 77 James St. North, Hamilton, Ontario 10, Canada.
Academy of Podiatry—Louis Lewy, 285 Madison Ave., New York, N. Y.
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American Foot Health Foundation—Sidney Hirschberg, 107-07 Continental Ave., Forest Hills, N. Y.

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M. J. Lewi College of Podiatry
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Chicago College of Chiropody
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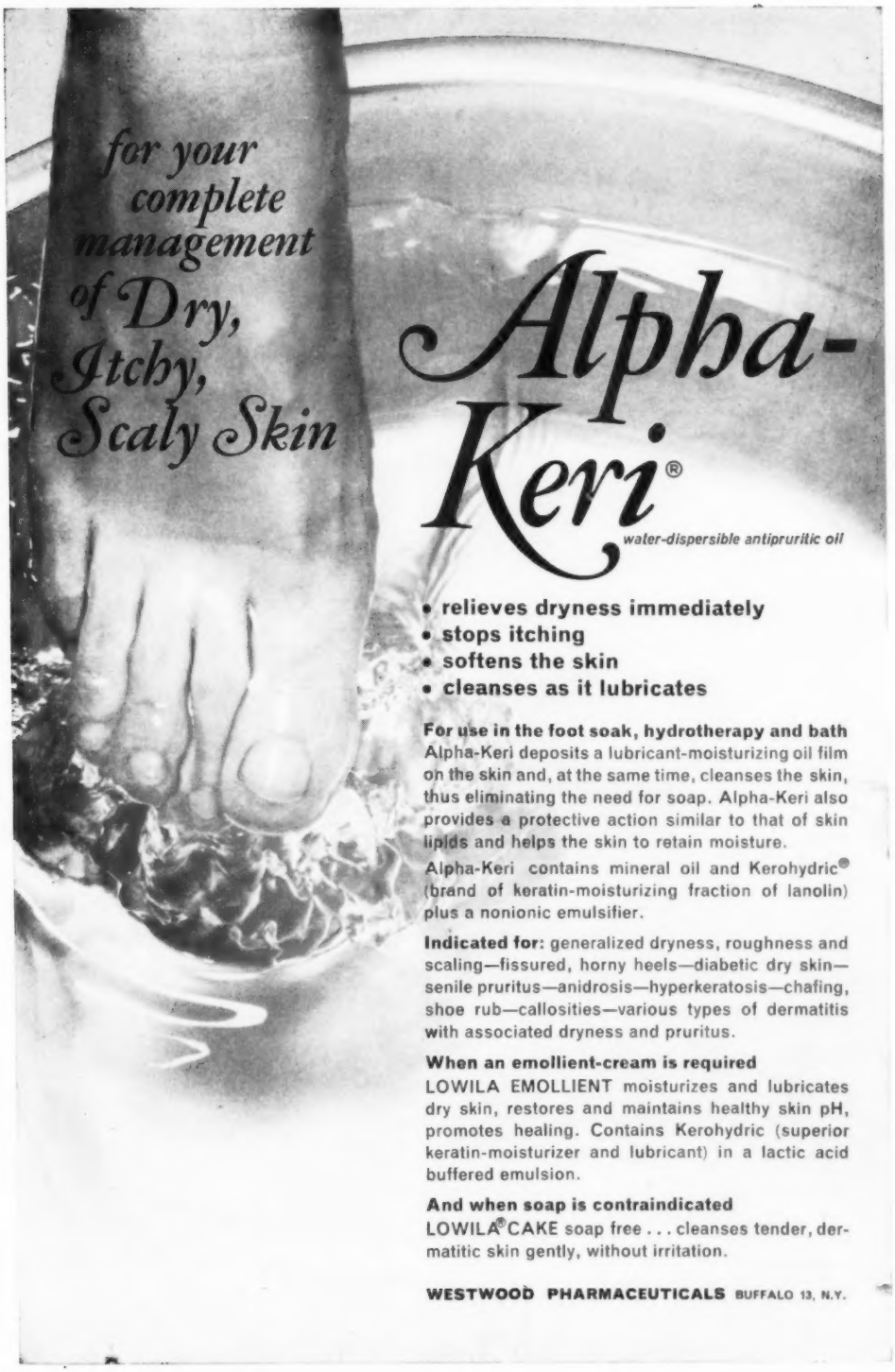
Ohio College of Chiropody
2057 Cornell Road, Cleveland, Ohio

Illinois College of Chiropody & Foot Surgery
1327 North Clark Street, Chicago, Ill.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STATE BOARD MEETINGS
FOR EXAMINATION AND LICENSURE

The National Board of Chiropody Examiners will conduct a four-day examination in recognized colleges; Part I will be given March 26-27, and Part II March 28, 29, 1962. **Secretary-Treasurer:** L. A. Hansen, D.S.C., 800 Professional Bldg., Kansas City, Mo.

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The Alabama Medical Board of Examiners. **Board** Secretary: Edward E. Sealy, 39 S. Perry St., Montgomery, Ala.

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Arizona State Board of Chiropody Examiners. **Board Secretary:** Martin Snyder, D.S.C., 2629 E. Broadway, Tucson, Ariz.

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Arkansas State Chiropody Examining Board. **Board Secretary:** Dr. Bernard S. Paul, 1508 Rogers Ave., Fort Smith, Ark.

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The California Chiropody Examination Committee will meet tentatively on March 6-7 and Aug. 21-22 in Los Angeles; June 19-20 in San Francisco; Oct. 16-17 in Sacramento. **Board Chairman:** Dr. Lawrence Garrett, 1413-2nd St., San Rafael, Calif. **Executive Secretary:** Mr. Wallace Thompson, 1021 O St., Sacramento 15, Calif.

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The Connecticut Board of Examiners in Chiropody. **Board Secretary:** Dr. F. J. Ruggiero, 3 South Main Street, W. Hartford 7, **Conn.**

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The Georgia State Board of Podiatry Examiners. **Board President:** Dr. Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

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The Idaho State Board of Chiropody-Podiatry. **Board Secretary:** Dr. J. E. Franden, 412 Eastman Bldg., Boise, Idaho.

Illinois

The Illinois Chiropody Examining Committee. **Superintendent of Registration:** Fredric B. Selke, Room 112, State House, **Springfield, Ill.**

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The Indiana State Board of Podiatry Examiners. **Board Secretary:** P. T. Lamey, M.D., 422 Citizens Bank Bldg., Anderson, Ind.

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The Iowa State Board of Chiropody Examiners. **Board Secretary:** Dr. C. C. Reinheimer, 111 W. 2nd St. South, Newton, Iowa.

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The Kansas State Board of Podiatry Examiners. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. N. Nash, M.D., 364 New Brotherhood Bldg., Kansas City, Kansas.

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Louisiana State Board of Medical Examiners. **Board Secretary:** Edwin Lawson, M.D., 930 Hibernia Bank Bldg., New Orleans 12, La.

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The Maryland Board of Chiropody Examiners. **Board Secretary:** Dr. S. Jack Kieger, 408 S. Division St., Salisbury, Md.

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The Massachusetts Board of Registration in Chiropody-Podiatry. **Board Secretary:** Dr. Charles H. Thorner, 910 Furnace Brook Parkway, Quincy, Mass.

Michigan

The Michigan State Board of Registration in Chiropody will meet for examination in June of each year. **Board Secretary:** Dr. Albert G. Kalin, 24453 Grand River Ave., Detroit 19, Mich.

Minnesota

The Minnesota Board of Chiropody Examiners. **Board Secretary:** Dr. Robert E. Ray, 512 N.W. Federal Bldg., Minneapolis, Minn.

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The Mississippi State Board of Health. **Board Secretary:** Archie L. Gray, M.D., **Box 1700, Jackson, Miss.**

Missouri

The Missouri State Board of Chiropody. **Board Secretary:** Frank Fulkerson, D.S.C., 611 Clay St., Chillicothe, Mo.

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The Montana State Board of Chiropody-Medical Examiners will meet the second Tuesday in January and July for reciprocity or examination at the Capitol Bldg., Helena, Mont. **Board Secretary:** Dr. L. M. Jennings, 411 First National Bank, Bozeman, Mont.

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The Nebraska State Board of Examiners in Chiropody. **Board Secretary:** Herman F. Gartner, D.S.C., First Natl. Bank Bldg., Lincoln, Nebr.

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The New Hampshire Board of Registration in Chiropody. **Board Secretary:** Edward W. Colby, M.D., 61 S. Spring St., Concord, N. H.

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The New Jersey State Board of Medical Examiners meets semi-annually for examination on the third Tuesday, Wednesday, Thursday and Friday of June and October. **Board Secretary:** Royal A. Schaaf, M.D., 28 West State St., Trenton 8, N. J.

New Mexico

The New Mexico State Board of Podiatry. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N.E., Albuquerque, N. M.

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State Board *(Cont.)*

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North Dakota

The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination at call at 301 Black Bldg., Fargo, N. Dak. **Board Secretary:** Joseph E. O'Brien, D.S.C., P.O. Box 872, Bismarck, No. Dak.

Ohio

The Ohio State Medical Board. **Examiner in Chiropody:** H. M. Platter, M.D., 21 W. Broad St., Columbus, Ohio.

Oklahoma

The Oklahoma State Board of Chiropody. **Board Secretary:** Dr. H. R. Johnson, 401 North Beard St., Shawnee, Okla.

Oregon

Oregon State Chiropodists' Examining Board. **Board Secretary:** Richard H. Wilcox, M.D., 914 State Office Bldg., Portland, Ore.

Pennsylvania

Pennsylvania State Board of Chiropody Examiners. **Board Secretary:** Dr. Jack S. Pincus, 26 N. 3rd St., Harrisburg, Pa.

Rhode Island

The Rhode Island Board of Examiners in Chiropody. **Administrator: Thomas B. Casey, 366 State Office Bldg., Providence, R. I.**

South Carolina

The South Carolina Board of Podiatry Examiners will meet for examination Aug. 6-10, 1962 at 122 W. Whitner St., Anderson, S. C. **Board Secretary:** Dr. James D. Hill, 122 W. Whitner St., Anderson, S. C.

South Dakota

The South Dakota State Board of Chiropody Examiners will meet at the discretion of the Board. **Board Secretary:** Viola Marr, 115 N. Main Ave., Sioux Falls, S. D.

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The Tennessee Board of Registration in Chiropody. **Board Secretary:** Stephen A. Lamm, 3355 Poplar Ave., Memphis, Tenn.

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The Texas State Board of Chiropody Examiners. **Board Secretary:** Dr. Lewis M. Hoppock, P. O. Box 3315, Temple, Tex.

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The Utah State Board of Chiropody Examiners. **Board Secretary:** Ward A. Burbidge, 1015 Medical Arts Bldg., Salt Lake City, Utah.

Vermont

Vermont Chiropody Association. **Board Secretary:** Gray S. Clark, Service Bldg., Rutland, Vt.

Virginia

Virginia Board of Medical Examiners. **Board Secretary:** Russell M. Cox, M.D., 509 Professional Bldg., Portsmouth, Va.

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The Washington State Chiropody Examining Committee usually holds Basic Science and Chiropody examinations the first and/or second week in January and July at the University of Washington, Seattle, Wash. **Board Secretary:** Thomas A. Carter, Administrator, Department of Licenses, Olympia, Wash.

West Virginia

Medical Licensing Board of West Virginia. **Board Secretary:** N. H. Dyer, M.D., 1800 E. Washington St., Charleston, W. Va.

Wisconsin

The Wisconsin State Board of Examiners. **Board Secretary:** Roy M. Cowen, 2266 N. Prospect Ave., Milwaukee, Wis.

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RALPH OWENS, D.S.C., F.A.C.F.S.	Pitfalls of Surgery
LOUIS M. NEWMAN, D.S.C., F.A.C.F.S.	Preparations for Membership in A.C.F.S.
V. A. JABLON, D.S.C., A.A.C.F.S.	X-Ray Positioning
TED ELLSWORTH	Health & Welfare Plans, Surgical Coverage
U. L. MEETER, M.D.	Urology—Its Relation to Podiatry and Podiatric Surgery
D. A. SCHUBERT, D.S.C., F.A.C.F.S.	The Role of the Abductor Hallucis in Hallux Valgus and Metatarsus Primus Varus

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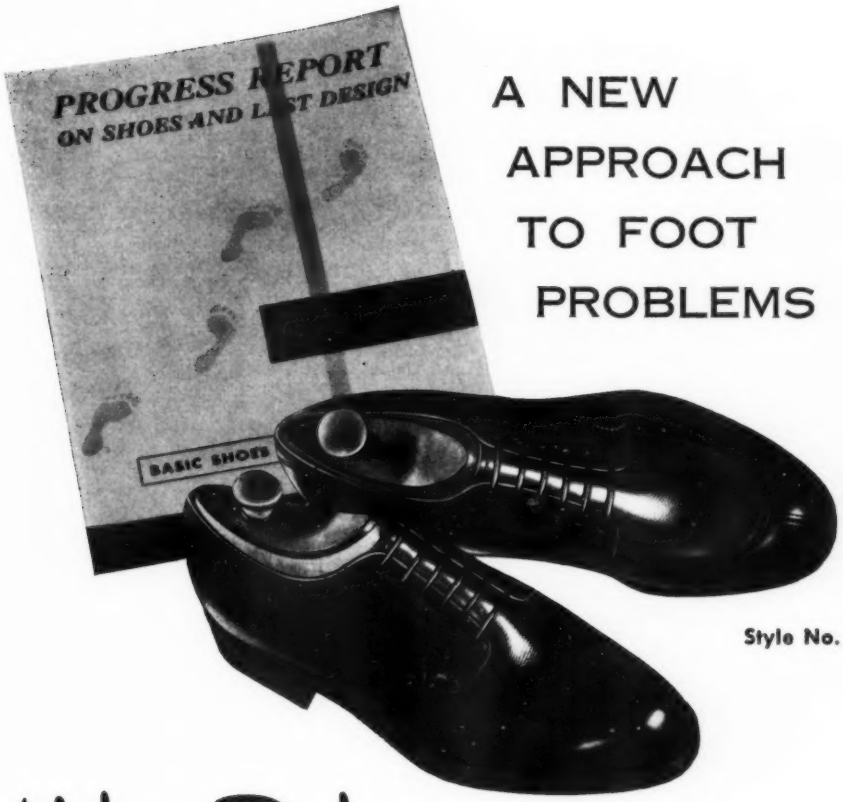
*Walker, M. H., Rubefacient therapy for the feet, *Journal of the American Podiatry Association*, vol. 50, Oct. 1960.



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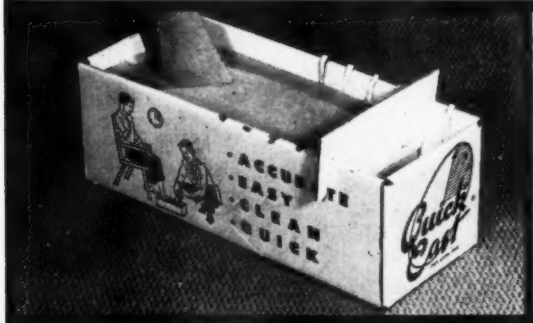

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Sublesional Administration of Corticosteroids*
A New Technique with Broad Applications in Podiatry

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ADMINISTRATION of corticosteroids by new techniques of intralesional and sublesional therapy offers a new approach to treatment of some of the highly resistant dermatoses that are commonly seen by podiatrists. The rapid resolution of these conditions under this new type of therapy offers possibilities that should not be overlooked.

This paper discusses a study of the new method, response of various types of lesions, optimum dosage, method of administration, etc. It has three objectives:

1. Provide background on the development of intralesional and sublesional therapy; show its applications in general medicine; compare its advantages and disadvantages with oral corticosteroid therapy.

2. Furnish detailed instruction on the specialized techniques required for this type of administration.

3. Illustrate, by citing clinical data on 48 patients, the specific applications and the great value of this form of therapy in podiatry.

* Condensed from Gold Award paper, The William J. Stickel Awards for Research in Podiatry-Chiropody for 1961. Presented at the Annual Meeting of the A.P.A., Americana Hotel, Miami Beach, Fla., August 1960.

First, however, it was necessary to obtain general background information on corticosteroid therapy in specific conditions and compare results of various routes of administration, i.e., oral, topical, etc. Following this, a survey was made of all known reports on intralesional and sublesional therapy. Triamcinolone was finally chosen as the most suitable steroid for testing of patients with specific podiatric problems. This choice was based in part on the following reports and our own previous findings[1, 2] and also because of its high potency and low rate of undesirable side effects.

General Review of Corticosteroid Therapy

Oral Corticosteroid Therapy

Following the discovery that cortisone exerted intense anti-inflammatory activity, imaginative experiments resulted in a succession of synthetic derivatives which opened broad horizons in medical therapy. Previously, naturally occurring substances extracted from the adrenal cortex were used principally for patients with adrenal insufficiency (Addison's disease) or for control of electrolyte imbalance. However, the

combination of hormonal, metabolic, and anti-inflammatory effects has provided relief for many conditions formerly debilitating or indeed fatal. A listing of some of the diseases which respond to corticosteroid therapy provides an imposing array of commonly seen clinical entities. Some of the diseases treated with corticosteroids are:

Rheumatoid arthritis
Bursitis
Bronchial asthma
Vasomotor rhinitis
Angioneurotic edema
Psoriasis
Other dermatoses
Leukemia
Lymphosarcoma
Hodgkin's disease
Disseminated lupus erythematosus
Nephrotic syndrome
Pulmonary emphysema
Pulmonary fibrosis
Rheumatic fever
Other collagen diseases
Blood dyscrasias
Inflammatory eye diseases

Therapeutic applications notwithstanding, it was soon realized that the picture was not quite as sanguine as it appeared. A wide variety of complications frequently became apparent, some comparatively mild and not very bothersome, but others so serious that they often outweighed the advantages of this type of treatment.

Among the major problems first noted were hypertension and edema resulting from a disturbance of electrolyte balance due to collateral hormonal effects of the drugs. However, mineralocorticoid and sex hormone properties were greatly reduced in the synthesis of triamcinolone while glucocorticoid activity, largely responsible for anti-inflammatory effects, remained. This fact would seem to account for the greatly decreased tendency of triamcinolone to induce sodium retention and resultant hypertension. Ward[3] has stated that among antirheumatic steroids, triamcinolone has the least tendency to cause sodium retention. Freyberg and coworkers[4] found that not only did no new cases of hypertension occur in their patients, but that sometimes existing hypertension was reduced. Hartung,[5] treating 77 patients, reported that in contrast to prednisone and prednisolone there was complete absence of edema and sodium retention in patients treated with triamcinolone. Since it does not produce edema, triamcinolone was found especially valuable in patients with rheumatoid arthritis complicated by cardiac decompensation.[6]

Another problem associated with corticosteroids and largely overcome by triamcinolone is the onset of voracious appetites in some patients undergoing prolonged steroid maintenance therapy. Triamcinolone has little or no effect upon appetite and is therefore preferable for overweight patients who require steroid therapy.[2, 4]

Change in mental equilibrium is numbered among the major complications associated with corticosteroids. Glaser[7] has reported a 5 per cent incidence of psychosis in patients treated with corticosteroids. Black[8] noted severe mental changes in 6 of 39 patients receiving prednisone. Euphoria is another complication, because the sense of well-being may result eventually in deeply rooted psychic depressions known to lead to suicide, paranoid and schizophrenic reactions,[9] and toxic syndromes sometimes leading to convulsions and death.[10] Such distressing effects have been much less of a problem with triamcinolone.[11]

These clinical reports and many others seemed to indicate the desirability of using triamcinolone in patients for whom corticosteroids are indicated. Triamcinolone, milligram for milligram, is at least as potent, and often more potent, than other steroids and is less frequently productive of major complications. It should not be construed, however, that the drug can be used without reservation. All general precautions associated with steroid therapy must be observed. Side effects are now quite familiar, and podiatrists have been forewarned to prepare for these complications when they arise.

Other Routes of Corticosteroid Therapy

In addition to the search for synthetic steroids with more selective activities, investigators sought new ways of administering the compounds. Why, physicians asked, subject a patient to full systemic activity of drugs when relief was sought only at particular sites? Systemic activity was not desirable for patients suffering from painfully inflamed arthritic joints, bursitis, or distressing local lesions To take advantage of potent local activity with minimal danger of serious systemic complications, new forms of corticosteroid preparations were developed.[1]

Steroids are produced as ointments, powders, lotions, creams, drops, sprays and other forms—each devised to exert potent local activity. While all serve useful purposes, they are valuable mainly as suppressants of acute symptoms; prolonged results usually are difficult to maintain.

Development of Sublesional And Intralesional Therapy

Local injections for skin disorders developed as a result of modification of a skin-testing method first suggested by Goldman *et al.*[12] Shelley, Harun and Pillsbury[13] used 0.05 ml of a sterile 1 per cent suspension of triamcinolone in isotonic sodium chloride solution to test the local effect of the compound in patients who were treated for psoriasis by oral administration. They found that lesions which did not respond to oral therapy also were unaffected by local infiltration. This result probably can be attributed to the very low strength of steroid employed. Cohen and Baer,[14] using a 2½ per cent suspension of triamcinolone, reported on several patients whose psoriatic lesions did not respond to oral doses, but were completely resolved by intralesional therapy. Larger doses are currently recommended, and apparently there have been no further reports of nonresponse to oral corticosteroids correlated with nonresponse to local sublesional therapy.

Technique of Sublesional Administration

Great confusion has prevailed over terminology connected with this form of treatment. Investigators have used phrases such as intralesional, intracutaneous, intradermal, subdermal, subcutaneous, and subepidermal to describe their techniques. It is no wonder that the practitioner when first contemplating this form of therapy easily becomes confused. Actually all the phrases are correct. Intralesional (literally, within the lesion) injections are reserved for those conditions such as keloids which are characterized by large raised masses of rigid, horny tissue, which must be injected directly to achieve favorable results. The other terms are descriptive of the techniques for treating the more common dermatoses—psoriasis, eczema, lichen planus, neurodermatitis, etc. It would be well for physicians to agree on such a term as sublesional, under the lesion, to describe the technique for treatment of most of these conditions.

It cannot be too strongly emphasized that rewarding results have a direct relationship to the manner in which the drug is injected into the skin. Injections given either too deeply or too superficially may lead to complications or lack of optimal benefit.

Infiltrations just below the border of the dermis and loose subcutaneous tissue are accomplished easily, provide generally reliable and consistent results and cause little discomfort to patients. Tuberculin-type or disposable syringes, equipped with 25 or 26 gauge needles, approximately one-quarter to five-eighths inch long are generally preferable. Under sterile conditions, the suspension is introduced through and beneath the lesion, approximately 4 mm below the surface of the skin. Proper administration produces a slight but noticeable swelling, but not a wheal. Multiple injections of small equal amounts of solution should be used for large lesions. The injections should be spaced evenly, about 1 to 2 cm apart on the periphery of the lesion. This process is continued until the midpoint is reached. Other methods such as tattooing and vibrapuncture have been used. While these methods are often effective they are less practical and more traumatizing to patients.[15]

Clinical Applications of Sublesional Triamcinolone

Review of general uses of intralesional corticosteroid therapy was followed by full evaluation of reports relating specifically to triamcinolone.**

The finding of Shelley and others,[13] which were cited earlier, seemed encouraging enough to stimulate other investigators to further evaluation of this new method.

Psoriasis long has been the bane of medical practitioners. In the past, almost all conceivable types of oral and topical therapies have been essayed. Among the therapeutic regimens thrown to the attack have been antitumor agents,[16] antimetabolites (aminopterin),[17, 18, 19, 20, 21] riboflavin,[22, 23, 24] B_{12},[25] D_2,[26] sulfonylurea derivatives[27] sitosterol,[28] atabrine,[21] antibiotics,[29, 30, 31] dextro-lactic acid,[32, 33, 34] allantoin,[35, 36, 37] tar and radiation therapy (Goeckerman regimen),[38] Grenz ray and roentgen therapy,[39, 40, 41, 42] and a host of compounded preparations for external application. None have afforded uniformly satisfactory results. Murrell[43] tersely summarized the situation when he said, "Psoriasis is the disease of specialistic frustration." Schamberg[44] calls it the "great dermatological mystery." But psoriasis and other less common but equally frustrating diseases, are now responding favorably to sublesional corticosteroid therapy. Cohen and Baer[14] have concluded that: "The persistent clearing (over 200 days) of psoriatic patches after intralesional injectional injection of triamcinolone in these "skin tests" suggests that intralesional injection of persistent localized areas of psoriasis may well be a worthwhile therapeutic procedure." Many subsequent studies have confirmed their observations.

Gerard[45] emphasized the need for proper technique, noting that best results were obtained when triamcinolone was infiltrated into the upper layer of loose subcutaneous tissue in patients with psoriasis. He found that results with triamcinolone were of a much more permanent nature than with similarly administered hydrocortisone. Of 19 patients, 13 had remained completely free of psoriasis for 18 months after initial treatment. On the basis of these and other observations he stated: "The remarkable results so obtained in psoriasis warrant the introduction of this technique into general dermatological practice."

James[46] found that intradermal injections of triamcinolone produced response in many other skin disorders—granuloma annulare, sarcoid of Boeck, neurodermatitis, lupus erythematosus, lichen simplex chronicus, and lichen planus. Slight atrophy of 3 or 4 months duration was the only side effect. Pelzig and Baer[47] successfully treated psoriatic plaques in 19 of 20 patients who received local injections of triamcinolone.

Hyman and Brezak[48] have begun a large study on the diagnosis and treatment of granuloma annulare. A preliminary communication states that intralesional injections of triamcinolone were successful in the first 2 patients of their series.

The following is a list of diseases for which sublesional or intralesional therapy may be indicated: Atopic dermatitis, Contact dermatitis, Eczema, Keloids, Lichen planus, Lichen simplex chronicus, Neurodermatitis, Nummular eczema, Psoriasis.

Orentreich,[49] who has carried on extensive studies with this form of therapy, has said: "The principle of treating isolated lesions by local infiltration with corticosteroids seems exceedingly helpful, in that systemic therapy may be discontinued, or reduced to a level compatible with long-term therapy with a much reduced incidence of side effects."

Results of Sublesional Administration of Triamcinolone in 48 Patients with Various Skin Disorders

It is now generally recognized that triamcinolone is one of the safest and most potent corticosteroids in use today. Podiatrists are aware of the value of its systemic activity in the treatment of many commonly encountered conditions. Recent reports of

** Both acetonide and diacetate forms of triamcinolone.

TABLE I

Responses Correlated with Total Dose Administered

Total Dose	Disease Treated	Response Excellent and Good	Fair
	Eczema	4	
6.25	Granuloma annulare	2	
	Lichen simplex chronicus	2	
	Psoriasis	3	1
	Eczema	3	
	Granuloma annulare	1	
12.5	Lichen planus	4	
	Lichen simplex chronicus	2	
	Psoriasis	7	
	Dermatitis venenata	1	
18.75	Lichen simplex chronicus	2	1
	Psoriasis	3	
25.0	Lichen simplex chronicus	1	
	Psoriasis	5	1
	Eczema	1	
31.25	Lichen simplex chronicus	1	
	Psoriasis	1	
37.5	Dermatitis venenata	1	
	Eczema, atopic	1	
	Dermatitis venenata	2	
50.0	Lichen simplex chronicus	2	
	Psoriasis	2	
62.5	Dermatitis venenata	1	
	Total	52	3

its application in local injectable form suggested the possibility of further rewarding results in podiatry. Psoriasis has been estimated to occur in as much as 1.4 per cent of the population.[50] It is a condition commonly seen in podiatry. This study was designed to test the effects of sublesional triamcinolone in patients with this and other conditions (granuloma annulare, lichen planus, eczema, lichen simplex chronicus (localized "neurodermatitis" and dermatitis venenata).

Method

Triamcinolone* diacetate parenteral suspension was used to treat 48 patients, 21 males and 27 females, with dermatoses of the lower extremities. The males had 2 from 11 to 20 years, 6 from 21 to 40 years, 9 from 41 to 60 years and 4 over 60. The females had 2 under 10 years, 1 in the 11 to 20-year group, 14 from 21 to 40 years, 8 from 41 to 60 years and 2 over 60.

No untreated individuals were used as controls since each patient acted as his own control. This method was found satisfactory since it was possible in all patients either to inject some lesions and not others or to inject part of a lesion and compare it with the response of the untreated part. In this way fully reliable evaluations could be obtained.

It should be stressed again at this point that no attempt was made to treat all lesions in patients who had widespread generalized skin involvement. It is obvious that it would be impractical and too traumatizing to patients to treat hundreds of diffuse lesions all over the body. After the value of this treatment was established the secondary goal was to clear exposed, cosmetically unpleasant areas of the body as rapidly as possible. This accomplishment would give patients a tremendous psychological boost. In some patients, however, there were relatively few

TABLE II

Courses of Treatment for Specific Diseases

	Patients	Number of Injections 1	2	3	4	5
Dermatitis venenata	5			2	2	1
Eczema	10	5	2	1	1	1
Granuloma annulare	2	1	1			
Lichen planus	4	4				
Lichen simplex chronicus	11	2	3	3	2	1
Psoriasis	20	4	8	3	4	1
Total	52*	16	14	9	9	4

*Some patients are counted more than once, since different areas received differing numbers of injections.

scattered lesions and it was possible to treat all affected sites.

Triamcinolone diacetate is supplied in vials as a parenteral suspension containing 25 mg/ml. Many physicians work with the full-strength solution. However, in this study the material was diluted with buffered normal saline to obtain a working concentration of 6.25 mg/ml. When required, the diluent was mixed with 2 percent lidocaine hydrochloride to alleviate the mild discomfort experienced by some patients. However, this usually was not necessary. It was felt that no more than 25 mg should be given to any patient in one week in order to minimize the possibility of systemic activity.

Under aseptic conditions and using disposable syringes equipped with 25 gauge, three-eighths inch disposable needles, the suspension was infiltrated with as little pressure as practical into the affected areas. Sufficient solution was introduced to raise a slight but noticeable area of swelling at each site treated. Injections were accomplished quite easily by holding the syringe at an angle of 30 degrees and inserting the needle through the lesion to a depth of 3 to 5 mm. It is not essential that every injection be made exactly at this level, and, in fact, some insertions resulted in intradermal penetration and others subdermal (hence the term "sublesional"). However, it is most important that the injections be given in the general area. Side effects, which will be discussed later, may result from infiltrations given either too superficially or too deeply.

Lesions treated ranged in size up to 56 cm^2, more commonly falling between 2 and 4 cm^2. For all larger lesions, the material was infiltrated by means of small equal doses spaced evenly around the affected area. Usually an entire lesion was not injected within one sitting. By treating just part of a lesion, comparative response with the untreated portions could easily be measured.

Total dose ranged from 6.25 to 62.5 mg. Correlation of dose and response for each type of disease treated is shown in Table I; number of treatments from 1 (16 patients) to 5 (4 patients), as indicated by specific disease in Table II.

Responses were graded on the basis of excellent, good, fair, or poor clinical improvement. Case report forms were prepared especially for this study in order that all pertinent information could be recorded and weekly progress of each patient noted.

The following data were recorded for each patient: patient characteristics (identification, age, sex) diagnosis, duration of disease, coexistent diseases, history of arthritis.

The date, method of injection, size of the lesion in centimeters, concentration and quantity of drug used and the site of the lesion were also recorded, as well as the clinical response of each patient.

The side effects, if any, therapeutic results and duration of remission of lesions, were noted at the bottom of each patient's chart.

TABLE III

Correlation of Diseases Treated and Clinical Response

Disease	No. Patients	Response: Excellent	Good	Fair
Dermatitis venenata	5	5		
Eczema, atopic	8	6	2	
Eczema, nummular	3	3		
Granuloma annulare	2	2		
Lichen planus	4	1	3	
Lichen simplex chronicus	11	9	1	1
Psoriasis	13	9	3	1
Psoriasis, generalized	5	5		
Psoriasis, pustular	2		1	1
Total	53*	40	10	3

*48 patients exhibited 53 clinical responses, since in some instances multiple areas treated did not all respond equally.

TABLE IV

Duration of Disease

	Less than 1 year	1-5 yrs	5-10 yrs	10-15 yrs	Over 15 yrs
Dermatitis	5				
Eczema	2	3	1	1	3
Granuloma annulare	1	1			
Lichen planus		1			
Lichen simplex chronicus	2	4	1		3
Psoriasis	2	8	5	2	3
Total	12	17	7	3	9

Results

Table III summarizes the clinical responses of 48 patients to sublesional administration of triamcinolone diacetate parenteral suspension. Results are tabulated on the basis of 53 responses for 48 patients. (In some patients different degrees of response were obtained in several areas.) Of the 53 areas treated 50 (94 per cent) showed good or excellent responses—a most rewarding and significant finding. The results were impressive in that some patients had been afflicted with their condition for as long as 27 years (Table IV) and many had complicating diseases such as arthritis and diabetes. Children as well as geriatric patients responded equally well. Many of these patients had exhausted the entire gamut of "cures" for psoriasis. Several individuals had developed deep-seated psychological manifestations, the result of years of cosmetic disfiguration. Certain of these conditions were accompanied by severe pruritic discomfort, which often was completely relieved within a few hours after the first injection.

Lack of systemic activity was marked by absence of response in all lesions other than those treated. This observation was further emphasized in that an injected portion of a lesion would clear while an untreated area of the same lesion would remain unchanged —a finding which clearly points up the very limited circulation of this drug when infiltrated in the proper manner. This is obviously a desirable consequence of therapy in these conditions. As a result no systemic side effects occurred. In certain patients an area or areas of a lesion were injected with triamcinolone while other parts were topically treated with such preparations as hydrocortisone and coal tar. While complete resolution of the injected areas usually occurred within 2 to 4 weeks, response in the other portion was much less rapid.

A "fair" response was observed in only

three patients. Of these, two did not return for follow-up therapy and were considered uncooperative. It is still too early to predict the permanence of the effects of this treatment based on this group of patients. However, some patients have been observed for as long as 5 months with no return of lesions in treated areas. Other investigators have observed complete maintenance of normal skin for much longer periods.[51, 52]

Clinical response was satisfactory regardless of the site of the lesions. Injections were made in all areas of the legs, ankles, feet, and toes. However, atrophy occurred more readily when lesions over bony prominences were treated. Atrophy and other local effects —no instances of which were considered serious—are discussed below.

Side Effects

Atrophy of skin which has been treated with local injections is a phenomenon peculiar to this form of administration. It appears to be technique-dependent rather than drug-dependent.

Atrophy, used in the sense of wasting away, does not afford a satisfactory description for the effect sometimes observed in areas where intralesional or sublesional injections have been administered. However, in lieu of a better term, atrophy describes the occasional instances of thinned out, shiny, sometimes depressed skin surface after it has been cleared of the original lesion. In the present study 11 such cases occurred. The relationship between total dose and incidence of side effects is illustrated in Table V. In most of these the atrophy was so slight as to be almost unnoticeable. Even where it was more prominent, this sequel to treatment was a welcome replacement of ugly, itchy skin lesions.

Orentreich[15] has observed that this is a temporary and reversible effect, and while it is too early to confirm his findings in the 18-patient study reported above, the effect does not appear worthy of undue concern. Gerard[45] and Scher[52] did not observe any atrophy in their patients. The true nature of this phenomenon and its etiology has not been established, but apparently it is more likely to occur when dose is excessive (not more than 75 mg should be given within a week) or when extensive pressure is applied during administration. This condition was observed more often in the bony regions, e.g. over the patellar, tibial, and metatarsal regions.

TABLE V

Correlation of Side Effects and Total Dose

Dose (mg)	Side Effect	Number
6.25	Atrophy	2
12.50	Atrophy	1
	Sterile abscess	1
18.75	Atrophy, slight	3
	Hyperpigmentation	1
25.00	Atrophy	3
	Discoloration	1
31.25	Atrophy	1
37.50		0
50.00	Atrophy	1
62.50		0
	Total	15*

*Based on total number of patients the incidence of side effects is 31 percent. However, this is not a realistic figure. Since literally hundreds of lesions were treated, the actual ratio of side effects to number of injections is very small.

The only other side effects were one instance each of erythema, hyperpigmentation, and sterile abscess. Gerard[45] observed mild to moderate erythema in areas which received relatively large amounts of triamcinolone. The inflammations disappeared in a few days, and were avoided entirely when the dose was lowered.

Discussion

The age of corticosteroids introduced a new system of therapy. Great success was obtained in many instances, but oral treatment engendered certain difficulties which seem to be eliminated by sublesional administration.

The primary consideration in choosing sublesional treatment rather than oral therapy for selected conditions is the absence of significant systemic activity when

corticosteroids are infiltrated locally and correctly. Potent activity is obtained at the site where it is most needed. The literature contains no reports of systemic activity resulting from local injections of triamcinolone.

The second motivation favoring intralesional over oral therapy in selected cases concerns the "rebound phenomenon" sometimes associated with orally administered corticosteroids. There are many reports citing recurrence or exacerbation of conditions, particularly arthritis and psoriasis, after oral steroid therapy medication is withdrawn. It is not uncommon for conditions to recur in a more aggravated or severe form than before institution of therapy. This has not been a problem with local infiltration of triamcinolone. Remissions have been maintained indefinitely (up to 18 months of observation) in some patients. These lesions which do regenerate are usually retreated with equally successful results.

Summary and Conclusions

Triamcinolone was administered sublesionally to 48 patients with various dermatoses of the legs and feet. Results were satisfactory in 94 percent of those treated. Gratifying results were obtained in patients who had suffered from intractable psoriasis of many years' duration, great cosmetic and psychological improvement being noted in these individuals. Side effects consisted mainly of atrophy, which was of insignificant consequence in almost all instances. This administration, performed as directed, is recommended for a great number of skin disorders commonly encountered in podiatry.

Acknowledgment

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References

1. Prentice, H.: *Combined Oral and Periarticular Triamcinolone in Podiatry:* A Preliminary Report, J. Amer. Podiat. Assoc. 50:896-901 (Nov., 1960).
2. Prentice, H.: *Steroids: A General Review and Evaluation,* J. Amer. Podiat. Assoc. (In Press).
3. Ward, L. E.: *Is There a Corticosteroid of Choice for Rheumatoid Arthritis* (Editorial), J.A.M.A. 170:1318-1319 (July 11, 1959).
4. Freyberg, R. H., Bernsten, C. A., Jr., and Hellman, L.: *Further Experiences with* Δ *1, 9 alpha fluoro, 16 alpha hydroxyhydrocortisone (Triamcinolone) in Treatment of Patients with Rheumatoid Arthritis,* Arthritis and Rheum. 1:215 (June, 1958).
5. Hartung, E. F.: *Triamcinolone in Treatment of Rheumatoid Arthritis,* J.A.M.A. 167:973-976 (June 21, 1958).
6. Hollander, J. L.: *Clinical Use of Dexamethasone; Role in Treatment of Patients with Arthritis,* J.A.M.A. 172:306-310 (Jan. 23, 1960).
7. Glaser, G. H.: *Psychotic Reactions Induced by Corticotrophin (ACTH) and Cortisone,* Psychosom. Med. 15:280-291 (July-Aug., 1953).
8. Black, R. L., Yielding, K. L., and Bunim, J. J.: *Observations on New Synthetic Antirheumatic Steroids and Critical Evaluation of Prednisone Therapy in Rheumatoid Arthritis,* J. Chron. Dis. 5:751-769 (June, 1957).
9. Bunim, J. J.: *Clinical Uses and Hazards of Adrenal Steroids and Their Analogues in the Management of Rheumatic Diseases,* Bull. N. Y. Acad. Med. 33:461-473 (July, 1957).
10. Good, R. A., Vernier, R. L., and Smith, R. T.: *Serious Untoward Reactions to Therapy with Cortisone and ACTH in Pediatric Practice,* Pediatrics 19:95-118 (Jan., 1957).
11. McGavack, T. H., Kao, K. Y. T., Leake, D. A., Bauer, H. G., and Berger, H. E.: *Clinical Experiences with Triamcinolone in Elderly Men,* Amer. J. Med. Sci. 236:720-735 (Dec., 1958).
12. Goldman, L., Flatt, R., and Baskett, J.: *Technique of Assay of an Unknown Steroid for Possible Local Activity in the Skin of Man,* J. Invest. Derm. 23:251-257 (1954).
13. Shelley, W. B., Harun, J. S., and Pillsbury, D. M.: *The Treatment of Psoriasis and Other Dermatoses with Triamcinolone (Aristocort).* J.A.M.A. 167:959-964 (June, 1958).
14. Cohen, H. J., and Baer, R. L.: *Triamcinolone and Methyl Prednisolone in Psoriasis,* J. Invest. Derm. 34:271-275 (Apr., 1960).
15. Orentreich, N., Sturm, H. M., Weidman, A. I., and Pelzig, A.: *Local Injection of Steroids and Hair Regrowth in Alopecia,* A.M.A. Arch. Derm. 82:894-902 (Dec., 1960).
16. Van Scott, E. J., and Reinertson, R. P.: *Morphologic and Physiologic Effects of Chemotherapeutic Agents in Psoriasis,* J. Invest. Derm. 33:357-370 (1959).
17. Cohen, E. L.: *Some New Treatments for Psoriasis,* Practitioner 181:618-620 (Nov. 1958).
18. Edmundson, W. F., and Guy, W. B.: *Treatment of Psoriasis with Folic Acid Antagonists,* A.M.A. Arch. Derm. 78:200-203 (Aug., 1958).
19. Gubner, R., August, S., and Ginsberg, V.: *Therapeutic Suppression of Tissue Reactivity: II. Effect of Aminopterin in Rheumatoid Arthritis and Psoriasis,* Amer. J. Med. Sci. 221:176-182 (Feb., 1951).
20. Rees, R. B., Bennett, J. H., and Bostick, W. L.: *Aminopterin for Psoriasis,* A.M.A. Arch. Derm. 72:133-143 (Aug., 1955).
21. Ziprkowski, L., Haim, S., and Bank, H.: *Atabrine in Psoriasis,* Acta. Med. Orientalia 13: 45-52 (1954).
22. Luscombe, H. A.: *Riboflavin in Psoriasis,* A.M.A. Arch. Derm. 74:548-551 (Nov., 1956).
23. Schiff, B. L., and Kern, A. B.: *Treatment of*

Psoriasis with Riboflavin, A.M.A. Arch. Derm. 78:643 (Nov., 1958).

24. Welsh, A. L., and Ede, M.: *An Appraisal of the Therapeutic Effect of Riboflavin in Psoriasis*, A.M.A. Arch. Derm. 76:595-600 (Nov., 1957).
25. Stingily, K. O.: *A New Treatment for Psoriasis*, Mississippi Doctor 32:222-223 (Jan., 1955).
26. Castanedo, C. A.: *A New Method of Treatment in Psoriasis*, Bol. Soc. Cubana. Derm. Sif. 12:14-29 (1955).
27. Kabelitz, G., and Kappel, W.: *Sulfonyl Urea Derivatives in Treatment of Psoriasis Vulgaris; A Preliminary Report*, Deutsch. Med. Wschr. 83:1167 (July 4, 1958).
28. Reinertson, R. P., and Wheatley, V. R.: *Studies on the Chemical Composition of Human Epidermal Lipids*, J. Invest. Derm. 32:49-59 (Jan., 1959).
29. Champion, R. H.: *Generalized Pustular Psoriasis*, Brit. J. Derm. 71:384-391 (Nov., 1959).
30. Ingram, J. T.: *Pustular Psoriasis*, A.M.A. Arch. Derm. 77:314-318 (Mar., 1958).
31. Stokes, J. H., and Ford, W. T.: *Observations on Treatment Mechanisms in Psoriasis with Special Reference to Terramycin*, J. Invest. Derm. 17:171-176 (Sept., 1951).
32. Kopecká-Avratová, B.: *Lactic Acid in the Treatment of Psoriasis*, Med. Klin. 53:1420 (1958).
33. Stefl, J.: *The Treatment of Psoriasis*, Med. Klin. 52:1967-1969 (1957).
34. Vogel, H.: *Dextrolactic Acid and Psoriasis*, Wein. Klin. Wschr. 72:30-32 (1960).
35. Bleiberg, J.: *Clinical Experience with a New Preparation for the Treatment of Psoriasis*, Ann. N. Y. Acad. Sci. 73:1028-1031 (1958).
36. Bleiberg, J., and Saltzman, J. A.: *Experience with a New Preparation in the Local Treatment of Psoriasis: A Preliminary Report*, Clin. Med. 5:485-488 (Apr., 1958).
37. Herdenstam, C. G.: *Allantoin in the Treatment of Psoriasis: A Double-Blind Study*, Acta. Dermatovener. 39:216-224 (1959).
38. Solomon, W. M., Netherton, E. W., Nelson, P. A., and Zeiter, W. J.: *Treatment of Psoriasis with Goeckerman Technic*, Arch. Phys. Med. 36:74-77 (1955).
39. Derzavis, J. L.: Grenz Ray Therapy: *A New and Effective Treatment for Psoriasis*, Med. Ann. D. C. 24:23-24 (Jan., 1955).
40. Frain-Bell, W., and Bettley, F. R.: *The Treatment of Psoriasis and Eczema with Grenz-Rays*, Brit. J. Derm. 71:379-383 (Nov., 1959).
41. Harber, L. C.: *Clinical Evaluation of Radiation Therapy in Psoriasis*, A.M.A. Arch. Derm. 77:554-558 (May, 1958).
42. Loewenthal, L.J.A.: *Treatment of Psoriasis with Grenz-Rays and Ultra-Soft Rays*, S. Afr. Med. J. 33:670-671 (Aug. 8, 1959).
43. Murrell, T. J., and Murrell, T. J., Jr.: *The Physician and the Psoriatic*, Southern Med. J. 40:355-358 (Apr., 1947).
44. Schamberg, J. F.: *The Known and the Unknown About Psoriasis*, J.A.M.A. 83:1209-1214 (Oct. 18, 1924).
45. Gerard, A. G.: *Treatment of Psoriasis with Subdermal Infiltration of Triamcinolone Diacetate Suspension*, A.M.A. Arch. Derm. 81:535-538 (Apr., 1960).
46. James, A. P.: *Intradermal Triamcinolone Acetonide in Localized Lesions*, J. Invest. Derm. 34:175-176 (Mar. 1960).
47. Pelzig, A., and Baer, R. L.: *Treatment of Psoriasis with Intralesional Injections of Triamcinolone*, J.A.M.A. 173:898-900 (June, 1960).
48. Hyman, D., and Brezak, S.: *Granuloma Annulare, A Clinical Note*, J. Amer. Podiat. Assoc. 51:126-127 (Feb., 1961).
49. Orentreich, N.: *Intradermal Triamcinolone Acetonide and Diacetate*, J. Urol. (In Press).
50. Forssman, H.: *On the Question of the Frequency of Psoriasis Among the Population at Large*, Acta. Dermatovener, 27:492-496 (1946-47).
51. Gerard, A. G.: *Subdermal Infiltration of Triamcinolone Diacetate Suspension in Different Dermatoses*, J. Med. Soc. New Jersey 58:110-111 (Mar., 1961).
52. Scher, R.: *Treatment of a Variety of Dermatoses with Intralesional Injections of Triamcinolone Diacetate*, Curr. Ther. Res. 3:132-136 (Mar., 1961).

Of greatest benefit to his fellows is the man who looks ahead with clear vision and with conscientious effort to achieve the good.

—*Confucius*

Management of Calcaneal Spur Inflammation with Triamcinolone Acetonide*

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THE list of indications responsive to treatment with corticosteroids is an ever-lengthening one. In addition to conditions of an arthritic nature,[1] a variety of other disorders in which inflammation is a factor, such as bursitis,[2] tendinitis[3] and inflammatory skin lesions,[4,5] can be effectively controlled by steroid administration.

The effectiveness of the steroids in arresting the inflammatory process has in fact been enhanced when direct routes of administration are utilized in preference to topical or oral administration. By procedures such as intra-articular[6, 7] and intradermal[4, 5] injection of steroids, the drug can be introduced to the site of inflammation with undiminished effect, simultaneously avoiding many of the untoward effects characteristic of systemic administration.

It was felt that injection of steroids at the site of inflammation might prove a valuable therapeutic measure in the symptomatic treatment of certain disorders of the feet, particularly in the management of calcaneal (heel) spur. This painful condition, which is often encountered among patients seen in podiatry practice, is caused by the development of a bony excrescence on the lower or plantar surface of the os calcis. Subsequent walking or standing with the involved foot causes the bony protuberance to bring pressure to bear on the surrounding tissue and plantar fascia. The inflammation which ensues causes pain, which is often severe.

The following study represents an attempt to determine the value, in terms of effectiveness of relieving pain and arresting inflammation, of the direct injection of steroid for patients with calcaneal spur.

Methods and Materials

The Patients

Results are presented for a series of six patients, five male and one female, between 43 and 75 years of age. The patients were seen in private podiatry practice. In each case, a diagnosis of calcaneal spur was established and confirmed by X-rays. The duration of the disorder prior to treatment as described here varied from several weeks in one patient to 5 years in another. For some patients, longitudinal padding in the shoes of the affected foot had been prescribed previously to relieve the strain on the plantar fascia and lessen pain. One patient in this series had also been on a program of oral corticosteroids, but this provided only transient relief of pain and was considered inadequate

The Medication and Treatment

It was decided to treat all patients in this study with direct injection of triamcinolone acetonide, 10 mg./ml., in the form of Kenalog Parenteral®[1]. A dosage of 0.5 cc or 1.0 cc, depending on the severity of pain and extent of inflammation, was injected at a frequency of no more than one injection per week. Duration of therapy varied from one to three weeks. In all instances, two or three injections sufficed, sometimes a single injection proving adequate. Only one patient required a total dose greater than 2.0 cc.

Previous to the actual injection of the triamcinolone acetonide, the skin of the foot at the injection site was prepared surgically using septisol and alcohol. Next, the area was anesthetized locally with ethyl chloride to minimize pain of the injection itself. 1½-inch needle, 23-gauge, was utilized to inject the drug. A medial rather than plantar approach directed at the tuberosity of the calcaneus was found desirable as this avoided the possibility of hitting the medial plantar artery. The needle was inserted until contact was made with the bone, then withdrawn approximately ⅛" and the contents of the syringe injected slowly. Concomitantly, sponge rubber heel seats were prescribed for most patients.

* Supplied for this study as Kenalog Parenteral by the Squibb Institute for Medical Research, New Brunswick, N. J.

®[1] E. R. Squibb & Sons, N. Y., N. Y.

TABLE I

Individual Response of Patients with Calcaneal Spur to Injections of Triamcinolone Acetonide

Patient	Sex	Age	Duration of Disorder	Dose (cc)	No. of injections	Total Dose	Toxic Effects	Response
1	M	57	2-3 mos.	0.5	2	1.0	None	Excellent
2	M	63	1 year	0.5	3	1.5	None	Excellent
3	F	75	4 years	1.0	2	2.0	None	Excellent*
4	M	50	5 years	1.0	3	3.0	None	Excellent
5	M	43	4-6 wks.	0.5	1	0.5	None	Excellent
6	M	43	4 mos.	0.5	2	1.0	None	Excellent

* Patient expired due to cardiac disease six months after end of therapy.

Results

Following are the case histories which are summarized in Table I. In every patient, symptomatic improvement in terms of reduction of pain by 90 to 100 per cent was achieved with the second or third injection of triamcinolone acetonide.

Case 1—Male, age 57, heel spur, medial tuberosity left calcaneous of 2 to 3 months duration. This patient received two injections of 0.5 cc. triamcinolone acetonide. Pain improved by 75% following the first injection; by 90% following the second. Symptoms have not recurred and patient is able to carry on daily tasks without pain or discomfort.

Case 2—Male, age 63, calcaneal spur, right heel of over 1 year duration. He received three injections of 0.5 cc. triamcinolone acetonide and pain improved by 90% after third treatment. Patient is now totally free of pain and is able to work and stand up all day.

Case 3—Female, age 75, now deceased, calcaneal spur, right foot, 4 years duration. She received two injections of 1.0 cc triamcinolone acetonide. The patient experienced 100% relief of pain by the second injection, even when bearing weight on the afflicted foot. The patient remained asymptomatic as regards her foot for the next six months, when she expired of cardiac disease.

Case 4—Male, age 50, calcaneal spur with secondary osteophytic bone changes in the right foot, 5 years duration. He received three injections of 1.0 cc. triamcinolone acetonide. With the third injection, the patient experienced 90% relief of pain and was able to resume his daily occupation.

Case 5—Male, age 43, calcaneal spur with secondary infero-medial tuberosity bursitis of 4- to 6-weeks duration. The patient had previously been on a regimen of 4 mg. triamcinolone per os, three times daily. When the patient had received a total of 64 mg. of the drug, therapy was discontinued but pain recurred after one week. A single injection of 0.5 cc triamcinolone acetonide was then injected into the foot. Within one week, all pain had disappeared. The patient happily demonstrated his ability to stomp his heel. Pain has not recurred and the patient was able to resume his work.

Case 6—Male, age 43. Acute, small heel spur of the right foot 4 months duration. This patient received two injections of 0.5 cc triamcinolone acetonide. Foot appliances and Ripple®-soled shoes were also prescribed. The patient noted 100% improvement following the second treatment and there has been no recurrence of pain.

Discussion

Several things appear significant in the responses of these patients to direct injections of triamcinolone acetonide. Firstly, in no instance were toxic effects of any kind in evidence. Although the series is small this suggests the drug is well tolerated when injected at the site of inflammation in doses of up to 1.0 cc at any given time. Secondly,

relief of calcaneal spur pain was dramatic and almost immediate—pain was actually lessened within approximately one minute after injection was completed. Thirdly, direct administration of the drug by injection into the foot seems to provide distinct advantages in comparison to oral therapy with triamcinolone as regards symptomatic improvement and recurrence of pain.

In approximately 50 per cent of patients there was pain at the injection site, but this never lasted more than 24 hours. Prior use of local anesthesia and employment of the medial approach when injecting can do much to minimize this pain. Triamcinolone acetonide also demonstrated a conspicuous absence of other untoward acute reactions, such as pain 48 hours following injection, and sloughing at the injection site, which this investigator has observed with other steroids, such as prednisolone.

Because the experiences with triamcinolone acetonide, as reported in this study, are based on a very small number of cases, any definite conclusion on the over-all effectiveness of this type of treatment must await further, more extensive study. It can be safely said, however, that the excellent results seen in the limited number of patients involved here suggest that triamcinolone acetonide administered by direct injection into the foot has great potential as palliative therapy for control of inflammation and pain associated with calcaneal spur.

Summary

Results of treatment of six patients with calcaneal spur are reported. Triamcinolone acetonide was injected in doses of 0.5 cc. and 1.0 cc. directly into the foot, utilizing a medial approach. In every patient, excellent results were achieved in terms of relief of pain. Two or three injections were sufficient to alleviate all pain and prevent recurrent episodes. As a result, patients were able to resume all normal activities. No untoward effects due to the drug could be observed.

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References

1. Hartung, E. F.: *Triamcinolone in Treatment of Rheumatoid Arthritis*, J.A.M.A., 167:973, 1958.
2. Bonner, C. D.: *Frequent Intrabursal Injections of Hydrocortisone Acetate for Bursitis*, Geriatrics, 13:581, 1958.
3. Hastings, W. D., Jr., and Hanna, C. E.: *Triamcinolone Acetonide (Kenalog) Injected into Joint and Muscle*, J. South Carolina Med. Assoc., 56:11, 1960.
4. James, A.P.R.: *Intradermal Triamcinolone Acetonide in Localized Lesions*, Antibiotic Med. & Clin. Therapy, 7:495, 1960.
5. James, A.P.R.: *Intradermal Triamcinolone Acetonide in Localized Lesions*, J. Investigative Dermatol., 34:175, 1960.
6. Schwartz, S.: *Intra-articular Use of Triamcinolone in the Treatment of Arthritis*, Monographs on Therapy, 3:51, 1958.
7. Norcross, B. M.: *Intra-articular Administration of Hydrocortisone in High Concentration: Use in Treatment of Arthritic Knees*, J.A.M.A., 167:839, 1958.

"Take fast hold of instruction: let her not go: keep her: for she is thy life."

—*Proverbs 4:13*

Painful Heel Spur Predisposes to Fracture

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THE importance of relieving a painful heel spur to prevent pathology in the opposite foot is shown in the case of this 55-year-old male.

Pain in the right heel had been diagnosed elsewhere by examination and X-ray as a calcaneal spur. Treatment then consisted of physiotherapy together with foam and sponge rubber padding in the heel but afforded very little relief. After several months of complaint, the patient decided that "he would have to live with it" and gave me a history of developing a gait which bore little weight on the affected heel but threw the maximum impact on the opposite foot in the metatarsal area.

After approximately 6 weeks of this type of imbalance, he noted a dull pain on the dorsum of the second metatarsal of the left foot. Since he recalled no specific injury, he kept putting his weight on this foot until it was too painful to continue walking. My diagnosis was march fracture from the history and X-ray examination. Examination revealed considerable swelling over the dorsum of the foot with tenderness over the metatarsal region, more marked over the involved bone. On the plantar surface, tenderness was very slight.

In march fracture, the X-ray appearance will vary according to the length of time that has elapsed since the onset of the condition. Taken 2 or 3 days after symptoms appear, the X-ray is usually negative for fracture. By the 10th day after the initial complaint, the X-ray will reveal some evidence of a fracture line or some early callus formation. There is rarely any loss of alignment of the fragments. After approximately 3 weeks, the callus appears overabundant for the size of the bone involved and the size of fracture.

Work involving long hours of walking or standing, especially on concrete floors, or the abnormal use of one foot, as in operating a foot pedal, may cause a march fracture The second or third metatarsals are the bones most commonly affected but the other three may be involved. Though fracture is generally on one metatarsal, it may occur simultaneously in two metatarsals, as in the third and fourth. The writer has seen patients recover from one fracture and soon after, have another occur in a neighboring metatarsal or in the opposite foot.

The child's foot may also be affected. Childress[1] reported a march fracture in a 7-year-old child. Typically, there was no history of trauma except that the child had been walking on a concrete sidewalk one-half mile, three times daily. Childress states that had the patient been examined during the acute stage, a diagnosis might have been made of osteomyelitis or even osteogenic sarcoma. He concludes that march fracture should always be considered in osteoblastic lesions of the metatarsal bones, even in young children. Bernstein, et al,[2] reported 724 march fractures in 692 patients. Krauz and Thompson reported 200 cases; Hulinger and Tyler reported 313 cases; Kernodle and Jacobs reported 82 cases. The writer, at a Marine activity on the West Coast,[3] saw 170 cases in approximately a 1-year period. Every man who complained of pain and swelling on the dorsum of the foot was suspected of having a march fracture and X-rays were taken.

The writer has described his method of immobilizing march fractures by the use of a leather shell strapped to the foot.[4] After a 4-week period the same shell can be used in the shoe.

In the writer's opinion,[5] pain in calcaneal spurs is really due to a bursitis in this area. Accordingly, ultrasonic energy was the treatment of choice, using an intensity of 2 watts per. sq. cm. for a 5-minute interval over the painful area two times each week. A direct crystal-to-patient contact was used. The

coupling medium was a hydrocortisone creme, Cort-Dome,®[1] the theory being that the ultrasonic energy might increase the permeability of the hydrocortisone. (Aldes,[6] in a paper entitled "Has Ultrasound Proved Successful in Clinical Medicine," shows ultrasonics flow effect had excellent drug dispersing properties if applied immediately after a drug injection. A personal communication from this investigator[7] states "In my experience, ultrasonic radiation does increase the permeability of the skin, thus allowing certain types of medication to penetrate into the underlying tissue.")

Ultrasonic therapy was followed by felt padding anterior to the inferomedian process of the calcaneus extending to the middle of the metatarsal shafts. After 5 weeks of treatments a cupped heel spring appliance was fabricated, the purpose of which was to take the weight off the painful area and relieve the process of the tension from the structures attached.

Examination 8 months later showed no recurrence of the march fracture or heel pain.

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®[1] Dome Chemicals Inc., N. Y., N. Y.

References

1. Childress, H.: *March Foot in a Seven-Year-Old Child*, J. Bone and Joint Surg., 28:877, Oct. '46.
2. Bernstein, A. et al.: *March Fractures of the Foot*, Am. J. Surg., 71:355-362, March '46.
3. Roven, M. D.: *Chapter on Military Podiatry*, Modern Foot Therapy, Foot Therapy Publishing Co., 1948.
4. Roven, M. D.: *Simple Fractures of the Metatarsals and the Phalanges*, J.N.A.C., 40:29, March 1950.
5. Roven, M. D.: *A Review of Ultrasonics and Some Personal Observations*, J.A.P.A., 50:641, August 1960.
6. Aldes, J. H.: Proc. Am. Inst. Ultrasonics in Med. 4th year, August 1955.
7. Aldes, J. H.: *Personal Communication*, Cedars of Lebanon Hospital, Los Angeles, Calif.

Ingrown Toenail and Hypertrophied Nail Lip Surgery by Electrolysis

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Paterson, N. J.

THE ingrown toenail is one of the most common conditions treated by the podiatrist. When this ailment is treated by merely removing a section of nail along the nail groove, in a matter of a few months time the ingrown nail usually recurs. Patients having this chronic nail problem welcome a surgical procedure that results in permanent correction.

The writer first described this nail technique in 1935 at a New Jersey Chiropodist's Society Symposium in a lecture entitled, "Negative Galvanic Current Used to Destroy Nail Matrix." Today, many podiatrists[1, 2] are using this procedure in preference to other techniques. The operation is an ambulatory, routine office procedure with minimal postoperative difficulty. In addition to these advantages the patient loses little or no time from work.

The description of reduction of hypertrophied nail lip is included in this paper because this condition is usually concomitant with the chronic ingrown toenail. A good result is assured by permanent narrowing of the nail in conjunction with reduction of the enlarged lip to normal size.

Nail Margin Adhesion

Callus formation in the nail groove results from irritation of the nail side against the nail groove. The adhesion of the nail to the nail groove, besides being painful as the nail grows in length, eventually tears the skin, providing an avenue for infec-

tion. Nail adhesion to callus in the nail groove, in the writer's opinion, constitutes a very large majority of the inflamed or infected ingrown toenails. Nail margin adhesion would be a more accurate description of this condition rather than ingrown nail.

Hypertrophied Nail Lip

When the inverted nail side presses downward into the nail groove, it not only deepens the nail groove but it also enlarges the nail lip. The enlarged lip now presents an additional problem, as it is constantly being irritated by the nail edge as the second toe presses against it.

Hallux Valgus Factor

Valgus movement of the great toe, pushing it against the second toe, is responsible for the lip being pressed against the nail edge. The friction of the nail against the nail groove forms callus. When this callus proliferates enough, it becomes attached to the nail. This interferes with normal nail growth. The writer's impression is that about 90 percent of all ingrown toenails occur on the side next to the second toe.

Hypermobility of First Segment Factor

Hypermobility of the first metatarsal segment is the factor that is mainly responsible for the foot rolling medially. As the foot is about to leave the ground the great toe is in contact on its medial plantar aspect forcing the great toe against the second toe. Therefore, the ingrown nail and the hypertrophied nail lip can be directly attributed to the hypermobile first segment in many instances. "Balance therapy" is advised for these cases in conjunction with surgical correction of the nail and reduction of the nail lip.

Instruments and Material

Materials required are: Galvanic Unit, Needle Holder, Birtcher® Needle #795-C (remove the white collar), syringe 1 cc. (tuberculin), needle 26 gauge 1 inch, electrode (wet) 4x5 inches, Tensor® bandage 3 inches x 2¼ yards, English nail forceps,

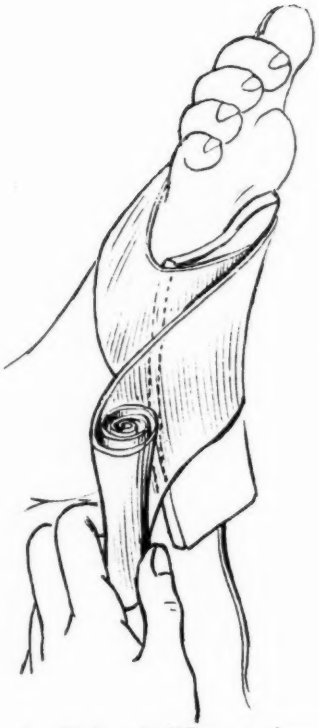

Fig. 1. Fixing indifferent electrode (positive electrode).

blunt ⅛ inch probe, Xylocaine®[1] 2% with 1 to 100,000 epinephrine. Skin is prepared as usual for surgery and the site anesthetized with the Xylocaine by a local field block. Additionally, the end of the toe receives anesthesia.

Surgical Removal of Nail Section

Remove a longitudinal section of nail about 3/16 inch in width using a long-nosed English nail forceps. Cut a straight edge extending to the base of the matrix without cutting into the skin of the mantle. Using a blunt probe, dissect the dorsal tissue attached to this nail section and free the deep attachment. Remove this nail section by first placing the probe under the nail section and using it to forcibly peel the callus from the entire nail groove. Try to leave the callus attached to the nail. Check the base of the removed nail section

[1] Astra Pharmaceutical Products, Inc.

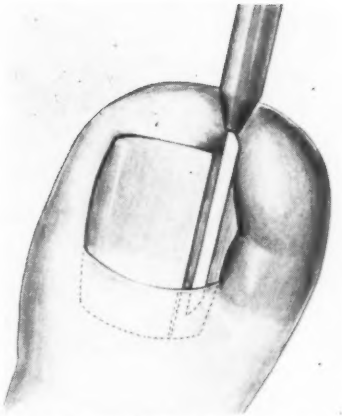

Fig. 2.—Electrolysis of nail matrix to prevent regrowth of removed nail section.

to see that there is a 90° angle corner where it was cut away from the main nail plate. Remove the additional corner of nail if necessary.

Negative Galvanic Procedure

Positive Electrode: A moistened electrode approximately 4x5 inches in size is securely fastened to the plantar surface of either foot with the 3 inch x 2¼ yards Tensor® bandage (Fig. 1). Any sensitivity under the wet electrode when the current is on means the bandage is loose or that a skin abrasion is present beneath the electrode. If so, tighten the bandage or change the site of the electrode to the other foot.

Negative Electrode: The Birtcher® #795-C electrode blade (saber) which has blunt edges is placed on all surfaces that the removed nail section contacted (Fig. 2). Advance the galvanic current to 8 or 10 milliamperes. When the patient feels a heat sensation, reduce the amperage until there is no discomfort. The average current strength used is 5 to 8 milliamperes. The milliamperage formerly used was 3 to 5 m.a. which required more time and increased the possibility of undertreatment. Using a gauze sponge to exert pressure against the side of the needle improves current contact. Exposure time is determined by disintegration of the matrix tissue. Proceed until the electrode contacts the phalanx. It should feel denuded of all cartilaginous and soft tissue. The flat blade of the electrode can be felt sliding over osseous area of the distal phalanx. Be certain that the extreme lateral corner at the base of the nail has been adequately treated. The nail bed and groove are also subjected to the current for about 30 seconds. Reduce the current to zero when withdrawing the electrode. The entire negative galvanic phase takes approximately 10 minutes for one nail side.

Reduction of Hypertrophied Nail Flap

Insert the electrode into the distal portion of the hypertrophied lip (Fig. 3). Guide the electrode into the center of the abnormally sized lip. Increase the milliamperage to 5, and as the tissue softens, roll the electrode in a circular motion from

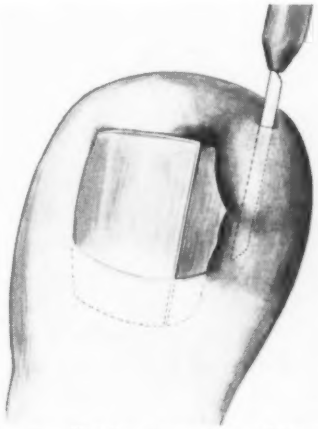

Fig. 3.—Reducing size of hypertrophied nail flap.

30 to 90 seconds, depending on the size of the flap to be reduced. Disintegration and liquefication of soft tissue occurs very rapidly.

Before applying the dressing, it is advisable to inject another cubic centimeter of Xylocaine to arrest hemorrhage and to give the patient an opportunity to reach home before the anesthetic wears off.

A water-soluble ointment is applied over the wound and covered with enough layers of sterile gauze to absorb blood and exudage that will drain from the wound. A

wedge of felt or cotton is placed deep in the web space between the first and second toe to keep the pressure of the second toe away from the lateral side of the great toe. A wet dressing is used in infected cases (Epsom salt solution or Furacin®[2] solution t.i.d.). Non-infected cases are soaked once daily in saline solution to encourage drainage of exudate resulting from the negative galvanism. Dressing should be changed twice weekly. The patient is instructed to wear a cut-out shoe.

152 Market St.

®[2] Eaton Laboratories.

References

1. Gardner, Philip, D.S.C.: *Negative Galvanic Current in the Surgical Correction of Onychocryptotic Nails*, J.A.P.A., 48; 12; 555-560; Dec. 1958.
2. Dyer, A.M., Cohen, M. F.: *A Report on the Use of Negative Galvanic Current for the Correction of Incurvated Nails*, J.N.A.C., 45; 12; 1955.

Clinically Speaking

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

Plantar Fistula—A Case Report

Sam D. Zebrack, D.S.C.
St. Louis, Mo.

THIS patient as first seen January 17, 1960, with the complaint of severe tenderness in a tylomatous region on the plantar aspect of her left foot. Examination disclosed arthritic changes in hands and feet, apparently of a rheumatoid nature. The tyloma in question seemed to make prominent the plantar aspect of the heads of the 2nd and 3rd metatarsals, though a similar excrescence of equal thickness was noted on the right foot as well.

History disclosed that patient had previously been under the care of an orthopedic surgeon who had prescribed her present footgear and who had advised her to have palliative treatment of these calloused areas periodically.

The tyloma palliatively reduced routinely. However, as the nucleated area was removed, a whitish liquid oozed. A probe was inserted for about ¼ inch into the tract which lay between the 2nd and 3rd heads and slightly anterior to their articulation with the base of their proximal phalanx. On withdrawal there was no blood on the instrument.

X-rays were requested and one dorsoplantar view was taken with a wire probe inserted into the lesion to determine how far and where this opening ran.

The X-ray report was: The AP views of the right and left feet reveal rheumatoid arthritic changes of the tarsi and metatarsophalangeal joints with subluxation of the right 2nd and 3rd toes, and the left 2nd toe. A metal probe was inserted into the fistulous tract on the plantar surface of the metatarsophalangeal joint area of the left 2nd toe. The tip of the probe passed to the plantar surface of the head of the second metatarsal bone, a distance of 1.5 cm. There is no demonstrable evidence of osteomyelitis noted at this time.

Summary: The fistulous tract extends to the head of the left 2nd metatarsal, a distance of 1.5 cm.

Since there was no evidence of osteomyelitis, the possibility of an old injury site was then explored. Stabbing wounds into the sole of the foot can be the cause of subdermal keratolytic[1] fistulas. However, no history of such an accident could be found.

Though this is not one of the normal sites for a sebaceous cyst, the possibility that this was the orifice of such a cyst was considered, since a white fluid had oozed from the lesion. However, these cysts are usually painless,[2] though in this location, pressure upon the sac could have caused pain on weight-bearing. No sac could be palpated.

Local treatment with a water-soluble antibiotic ointment and boric acid soaks freed the area of fluid, even when the channel was

held open and pressure expression was attempted.

The patient was referred back to her surgeon with a report of our findings, stating that in our opinion, excision of the lesion would leave the patient with a vulnerable scar.

It was decided to treat this lesion mechanically to avoid surgery, since "the cure" could easily cause more difficulty than the condition. She was then strapped and padded accommodatively to avoid pressure of weight bearing. (The right foot was treated similarly.)

One week later the patient returned asymtomatic, and the same therapy was repeated. The patient was scheduled for impression for an appliance at the next visit. This was constructed to prevent stress to the 2nd head and the interspace between the 2nd and 3rd metatarsals. The patient was then reappointed for 1 month, at which time the tyloma was noticeably thinner in texture, and though the orifice of the fistulous tract was open, it was clean with no oozing of fluid. Proper hygiene and the use of Panthoderm Cream®[1] was prescribed, with the patient to return periodically during the year for therapy.

This case illustrates the many conditions seen by the podiatrist, where actually pinning down the etiology of the condition is impossible. This lesion could have been due to: (1) pressure necrosis from the subluxated 2nd digit, (2) an earlier case of osteomyelitis, (3) secondarily infected cyst, (4) injury.

Recognition of the extent of the lesion and watchful carefulness during care produced a successful result, without resorting to surgery.

6802 Gravois Ave.

References

1. Zebrack, Sam D., D.S.C., *Subdermal Keratolytic Fistula—A Case Report*. J.N.A.C. Vol. 47, No. 8., P. 402.
2. Greenbaum, Sigmund S., M.D., *Dermatology, Diagnosis and Treatment*, F. A. Davis Co., Philadelphia, 1949, p. 672.

®[1] U. S. Vitamin Corporation, New York, N. Y. (Arlington-Funk Laboratories, division.)

Emollient Vitamin A Therapy

William O. Wattling, M.T., D.S.C.*
Lewiston, Idaho

Following is a summary of 13 cases of skin dryness treated at a state mental institution. No attempt has been made to separate these cases as to cause and it should be understood that their causes were varied. Color slides were taken before and after treatment. Conditions were classified as follows: light, meaning local areas of dryness about the foot; moderate, meaning areas about the foot and leg; severe, meaning areas about the foot, leg and body with heavy hyperkeratosis, crustings and/or fissuring.

Patients in custodial care receive, from necessity, less bathing than our regular office patients. Soaks of 15 minutes, without additives, were ordered followed by a brief scrub each day. Two weeks of this care showed little improvement. These patients were then ordered to rub, or have rubbed in, twice a day, Lowila Emollient®[1]. At the end of 2 weeks of this care, 11 of the 13 cases had improved one grade.

The two cases not responding and three of the others were then placed on vitamin A therapy (A/50 Capsules®[2] 50,000 units b.i.d.). After the administration of 100 capsules, our results were: two of the five had a most marked change and were noticeably better; one was less dramatic, and in two cases there was no visible change but we did observe a change in "feel" and texture which was deemed beneficial.

This limited study suggests that a greater and more detailed study would reveal that Lowila Emollient is of help in most types of dryness and that the effect is enhanced when combined with oral Vitamin A therapy.

Suite 513, Breier Bldg.

* Consultant in Podiatry, State Hospital, North Orofino, Idaho.

®[1] Westwood Pharmaceuticals, Buffalo, N. Y.
®[2] Podiatrex, Glendale, Calif.

JOURNAL
OF THE
AMERICAN PODIATRY
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A. RUBIN, D.S.C., Editor

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.

President's Message

Podiatry Education

During the coming year we shall celebrate the 50th Anniversary of our Association. In this short period of our existence, we have overcome many seemingly insuperable problems.

Your Association labored, and continues to labor, to bring to our members dignity and security. We have endeavored, and continue to endeavor, to build a better profession to assure our stability.

One of the many problems facing our profession, and one of the gravest, is the upgrading of our educational institutions. May we as individuals recognize our moral responsibilities. The process of providing better education, research, and finally, recognition begins with the podiatrist-chiropodist and not with theories or systems. Our profession is no better than the doctors who make it up, no wiser than the way they think, and no more sensitive than the way they feel.

Our profession has made tremendous strides in the past decade and there are practically no limits to the further progress it can make with a unified front.

Podiatry-chiropody has reached another crossroads in its short history. As in all healing arts professions the Association is constantly striving to improve the quality of the profession's educational system. This is your problem — our problem. We are privileged to play a part in its solution.

Sterling M. M'Murrin, U. S. Commissioner of Education, Department of Health, Education, and Welfare, in a report to a congressional committee, made the following statement. His remarks could well have been directed to the profession of podiatry-chiropody. I quote, "We are not yet willing to invest in education that measure of our resources that will give us . . . a guarantee of success. By resources of course, I do not mean simply financial resources. It is too characteristic of us to assume that money will solve all of our problems—money for more buildings, more research equipment,

more scholarships and fellowships, more teachers, and higher salaries. Money will solve no problems whatsoever without talent, energy, creative initiative, inspiration, and plain hard work. But our problems will not be solved without more money, and far more, than is now being invested in our educational establishment. They will not be solved without those student loans, fellowships, and higher salaries. If we continue to pay only the price of second- and third-class education we will deserve to suffer the comparative decline of our intellectual life that will inevitably be upon us. If we intend to remain in the first rank of intellectual achievement, of scholarly and scientific and technological advancement, we must accept the fact that a larger share of our income than the allowance now made must be invested in education."

As a result of the foresight of Dr. Abe Rubin with his subsequent recommendations to the Board of Trustees and the Council on Education, action was taken at the 1960 House of Delegates authorizing the establishment of the Special Commission on the Status of Podiatry Education. "The profession of podiatry recognizes that it has a major obligation to society to insure that there shall be an adequate supply of well-trained professional people caring for the nation's foot health problems. In accordance with this policy, the Special Commission on the Status of Podiatry Education is herein requested to examine, from a broad point of view, the profession's educational program and advise steps necessary to improve this program."

Once again we are indebted to our Executive Secretary, Dr. Rubin, who, through personal friendships, was able to obtain the services of such eminent educators as Dr. William K. Selden and Dr. Lloyd E. Blauch. In turn they arranged for other eminent educators, Dr. I. L. Baldwin, Dr. Leland Powers, and Dr. George Guenzler, thus comprising the full Commission. The American Podiatry Association is grateful to these fine gentlemen for devoting their time unselfishly to aid podiatry in its quest to improve its educational standards.

Our members are now aware that the Special Commission has completed its study and has submitted recommendations to the American Podiatry Association.

The Board of Trustees and the Council on Education are working diligently, implementing many of the recommendations of the Commission. For example, work has already begun in developing an acceptable definition of the profession of podiatry as a distinct and identifiable branch of the healing arts.

The report by Dr. Selden before the House of Delegates was enthusiastic and impressive. Consequently, the delegates showed an extraordinary brand of determination and conviction by voting a $10 assessment of all members each year for educational purposes.

The Special Commission has enabled us to pause long enough to look back along the path—to re-examine ourselves—to determine whether the profession is meeting its current and prospective responsibilities and finally, to help bring the problems of podiatry education into sharper focus. The helmsman steers the ship more efficiently if he takes an occasional look at the log as well as the chart and compass.

At this time the eyes of every member should be focused on our objectives. There is no time for selfish indulgence. I plead for each member to emphasize not what he will get, but rather the contribution he can make to the advancement of his profession and the public welfare.

Over 400 years ago, Francis Bacon wrote: "I hold every man a debtor to his profession, from which men seek to receive countenance and profit, so ought they in duty endeavor themselves by way of amends to be a help and ornament thereunto."

In this way we as a profession will reach the apex in our development to bring better foot care to a foot-weary mankind.

ROBERT SHOR, D.S.C.

Introductory Comments to Discussion of the Report Of the Special Commission on Status of Podiatry Education

William K. Selden, LL.D., Chairman*
Washington, D. C.

Since the meeting this afternoon has been arranged to provide an opportunity for general discussion of the recently completed report on the present status of podiatry education, I am intentionally limiting these more formal remarks to only one or two of the basic issues confronting the profession of podiatry. By limiting my remarks I hope to give encouragement to an unrestricted discussion on the part of all present, of the recommendations contained in this report.

If you could have heard any of the discussions at our commission meetings you would have appreciated that none of us were inhibited in considering and discussing issues related to podiatry education. This may be one of the factors why each member of the Commission—Dr. I. L. Baldwin, Dr. Lloyd E. Blauch, Dr. George E. Guenzler, Dr. Leland Powers and I—thoroughly enjoyed our assignment. I should be remiss if I did not also mention that we are grateful to Dr. P. R. Brachman and Dr. Abe Rubin for the assistance which they gave readily and willingly in response to any question which the members of the Commission directed to them. However, I must emphasize that we of the Commission collectively assume all responsibility for the comments and recommendations contained in the report.

We are likewise appreciative of the very definite spirit of cooperation which the members of the Commission encountered on our visits to each of the colleges. The deans and those members of the faculties whom we met appeared desirous of helping us so that our report would be constructive and would lead to further improvement in education for the profession of podiatry.

You will recall that our assignment from your Board of Trustees stated—"the Special Commission on Status of Podiatry Education is herein requested to examine, from a broad point of view, the profession's educational program and advise on steps necessary to improve this program." The Commission endeavored to follow this mandate even though in the time available it was not an easy task.

Undoubtedly there are different phases of podiatry education to which some of you wish we had given more attention, and others regret that we did not make more detailed and specific recommendations. In contrast to this approach we considered it our mission to provide a broad outline for the profession so that you—its members—could more readily assume your individual and collective responsibilities in helping to improve the education for your profession.

We endeavored to be direct in our observations and recommendations and to describe conditions as accurately as we saw them. We have anticipated that voices would be raised, if they have not already been heard, suggesting that the report will do more harm than good to podiatry as well as to the reputation of the members of the profession. Such a reaction is usual. It has developed in response to the significant reports made for other professions. We should not expect that podiatry would be an exception in this regard.

In reply to those who might be unduly disturbed and fearful of a report which publicly describes weaknesses in an educational program, I wish to emphasize the fact that a profession, to qualify for the distinction of being called a Profession, must fill a position of public trust. Part of such trust entails public accountability. Consequently, this report is intended to advise not merely the members of the profession, but also the general public, what a commission com-

*Formerly President, Illinois College, presently Executive Secretary, National Commission on Accrediting.

posed largely of non-podiatrists considers to be the strengths and weaknesses of the educational program which prepares podiatrists for their service to the public.

Improvements in the education for a profession will not result by a profession avoiding consideration of basic issues, nor will support from without a profession be developed if a profession fails to exercise its stewardship. Your Board of Trustees, acting on your behalf, had exercised stewardship by creating this Commission, on which I have had the sincere pleasure of serving, and by assigning it freedom to inquire and to report.

Let us recognize frankly that our report will cause some worry and heartaches, if not sore feet. It is bound to bring at least a few disappointments and even criticisms. These manifestations are part of the struggle which must be faced whenever attempts are made to introduce improvements, especially improvements which affect an educational program. Recriminations and undue criticisms will not encourage betterment but will foster ill feeling and dissension. Improvement and betterment in podiatry education will be developed most rapidly if your profession provides the proper leadership in a committed and united manner. This observation leads me more directly to the report itself.

As I have reviewed my printed copy and have restudied our observations and recommendations, I have been reminded of a musical composition in which a theme is stated at the beginning and then followed by a series of variations on the same theme. In this report, there are two main themes which are interwoven with each other. Whether attention is directed to the need for clearly developed and stated objectives, or to the appropriate organization and administration of the colleges, or to an adequate number and proper location of schools, or to facilities and libraries, or to research, or to accreditation, or to the Council on Education of the APA, or to external relations or to university affiliation —no matter to what items attention is directed, these two themes appear and reappear.

To the initial reader the dominant theme is that of money. It takes money to employ full-time faculty and administrative officers. It takes money to construct adequate facilities and laboratories, clinics and libraries. It takes money to employ research personnel and to finance their studies and explorations. It takes money to provide scholarships for students whose present numbers are insufficient. It takes money to organize additional colleges of podiatry. It takes money to devise new curricula and to support graduate and postgraduate education. In fact, it takes money to attract money for the adequate support of podiatry education.

Unquestionably some trustees of each of the five colleges of podiatry have exclaimed —"if we only had a million dollars," or with more recent increased costs—"if only we had a couple of million dollars." Such expressions give recognition to the immediate and pressing needs of the colleges, and these comments support what many will consider to be *the* dominant theme of this report. There was no doubt in the minds of any of the members of the Commission that financial support is needed, and desperately needed to assist in the strengthening of podiatry education for the benefit both of the profession and of society. But I contend that this is the secondary or subordinate theme compared to the really dominant theme of the report—that of personnel.

For a few moments let us consider the implications of this statement. Among the qualities which the members of a profession must possess are knowledge and judgment—qualities which are in demand in any society, and especially so as the society becomes more complex. We find today that in the midst of our rather sizeable unemployment we have widespread unsatisfied demands for individuals with knowledge and judgment. This situation prevails in all the professions, only in podiatry it is much more acute.

First of all, each college of podiatry is in need of more students and a larger number who are more academically qualified. Second, all colleges need a nucleus of full-time faculty members who can devote their time and attention to purely educational matters—teaching, curriculum, course development, and educational planning.

Third, the colleges need to make a small number of appointments of individuals with abilities for research. Fourth, the colleges must have larger staffs of full-time administrative officials who are prepared and capable of providing educational leadership and who can command respect from the faculties and students, from the members of the profession and other professions, as well as from manufacturers, foundation officials, and the public. Fifth, the boards of trustees of all the colleges must comprise individuals who have vision and imagination, who are dependable and conscientious in fulfilling their responsibilities, who have a commitment to podiatry education of high quality, who are willing to spend considerable time and effort to support its marked improvement, and who are prepared to make some difficult decisions on the basis of what is best for the public welfare. Sixth, all of these requirements are basic to a strong profession of podiatry with members who possess among other qualities—knowledge and judgment.

Money alone will not bring the results which the members of the Commission envisioned and which the members of your profession desire. However, money will help to make possible the attainment of these goals, provided there is vision and leadership which will attract the support of those who have money to contribute. Let us remember that vision and leadership depend upon personnel. Thus, the two major themes in the report are personnel and money and in this order of importance.

In concluding these introductory remarks let me anticipate a question which is undoubtedly in the minds of many of you and which was addressed to me by members of your Board of Trustees when several of us from the Commission met with them in June—where to begin when there is so much to be done? If personnel is basic to improvement in podiatry education, from where does the expanded and strengthened personnel come? Strengthened and expanded personnel is needed among the student bodies, among the faculties and administrative staffs, and among the trustees. And the improvement of personnel in one area is in turn dependent upon improvement in personnel in each of the other areas. Everything cannot be accomplished at once. There must be some priority of implementation.

Responding to this anticipated question, I will state that the initial steps must be taken on many fronts simultaneously but that one which must be resolved first to make possible the eventual resolution of the others, is a strengthening of the boards of trustees.

Final authority for the operation of each college rests with its board of trustees which is legally responsible for its operation, which appoints the chief administrative officer, which approves the appointments of faculty and staff members, which approves the plans and construction of physical facilities, and which is responsible for the fiscal solvency of the institution. A weak board of trustees usually means a weak and ineffective institution, no matter what type of educational institution is involved. A responsible and effective board of trustees will generally insist on a strong college with reasonably adequate funds to support the institution. And a responsible and effective board of trustees is dependent upon personnel.

From where can the impetus come to initiate all the improvements called for in this recent report? The Special Commision on Present Status of Podiatry Education believes that it will come initially from the members—that is the personnel—of the American Podiatry Association. As we indicated in the conclusion of our report, the accomplishments which have already been attained in podiatry have largely been the result of the efforts of the profession itself. You have demonstrated capacity and will.

For our part we have merely suggested ways for further improvement in podiatry education which deserves, and should be attracting, the support of others outside the profession. But this support will depend upon your initiative, your efforts, your further demonstration of capacity and will. I have no doubt that you will meet the common needs of your profession and of our society.

1786 Massachusetts Ave., N.W.

Pharmaceutical Preparations for the Profession

Harry L. Hoffman, Ph.G., D.S.C.
Chairman, Council on Podiatry, Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday podiatry practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Absorbine Jr. Liquid

With the introduction of new medications we oftentimes lose sight of the use of long established remedies that have been beneficial to mankind through the years. Absorbine Jr. liquid is such a product. It is a time-honored nostrum with some modern additions.

Composition: Its active ingredients are wormwood, thymol, methol, acetone and chloroxylenol percolated and blended from the original formula of Wilbur F. Young.

Indications: For control of dermatomycosis, relief of pain of insect bites and stings, sore leg muscles, burns, neuralgias, inflamed corns and bunions, sunburn, fissures and ankle sprain.

Action and Uses: Chloroxylenol, known also as YG-7, kills fungi, vegetative bacteria and spore forming bacteria. It is an effective antifungal, antiseptic when applied to vesicles or pustules. As a wet dressing 1:10 Absorbine Jr. liquid is useful in reducing inflammation of ingrown nails and callused nail grooves. Foot fatigue pain is diminished and routine podiatry treatment is pleasantly terminated with Absorbine Jr. liquid.

Administration: Apply morning and night to the feet for prophylaxis or as needed to curb infection.

Supply: In 1 oz., 2 oz., and 4 oz. bottles with a unique sponge applicator or a family size 12 oz. bottle. By W. F. Young Co., Inc., Springfield, Mass.

Fulvicin

Description: This is griseofulvin, an antifungal antibotic which is orally effective against superficial fungus infections (ringworm) of the scalp, beard, body, hands, feet, fingernails and toenails. Orally administered griseofulvin is absorbed from the gastrointestinal tract and deposited in fungistatic concentrations in the newly growing skin, hair and nails which, with shedding or cutting, are replaced by normal structures free from fungi. Results with Fulvicin therapy have been almost uniformly excellent, regardless of duration of the condition. Decrease or relief of itching and inflammation can be noticed within a few days. In some cases the skin may appear normal clinically in perhaps 10 days.

Indications: Tinea capitis, barbae, cruris, corporis and pedis as well as onychomycosis, when these conditions are caused by Trichophyton mentagrophytes, rubrum, schoenleini, sulphureum, verrucosum and interdigitale; Epidermophyton floccosum, or Microsporum gypseum, canis and audouini. *Before* Fulvicin therapy, it is advisable to determine the responsible organism by suitable culture techniques.

Dosage and Administration: Administered orally in divided daily doses until at least 2 weeks after the patient shows no clinical signs of fungus infection, or after repeated laboratory tests prove negative for fungi. Adult dose, 1 gm. daily is adequate for most conditions. In severe cases or extensive infections, up to 2 gms. a day may be given initially, with reduction to 1 gm. or less daily when definite clinical response is noticed. Children weighing 30 to 50 lbs., 0.5 gm. daily; children weighing more than 50 lbs., 0.75 gm. daily.

Usual Length of Therapy: Tinea corporis and cruris, 2 to 4 weeks; tinea capitis and barbae, 4 to 6 weeks; tinea pedis, 3 to 6

or longer; onychomycosis, 4 to 6 months, although toenails often require 12 months or more. Should a plateau occur in response, a dosage of 2 gm. daily may accelerate recovery, folowing which it may be lowered to 1 gm. daily.

Side Effects: To date there have been minimal side effects which have proven transient. There have been occasional reports of heartburn, nausea, epigastric discomfort and diarrhea. In a few cases urticaria or drug rashes have developed. *In such cases, the medication should be discontinued.*

A few patients have complained of headache during the first week of therapy, and there have been occasional reports of lethargy, fatigue and/or psychomotor incoordination following oral administration of Fulvicin.

Precautions: Clinical studies with Fulvicin to date have not revealed evidence of serious toxicity. As with any new medication, patients on prolonged therapy should be kept under close observation. An accasional patient has shown a tendency toward leukopenia which promptly disappeared when therapy was discontinued. Therefore, it is suggested that complete blood counts be performed at intervals and patients be watched for sore throat, fever, or other abnormal signs or symptoms. Although Fulvicin is derived from a species of Penicillium griseofulvium, a number of known penicillin-sensitive patients have been treated without difficulty. Nevertheless, the *possibility* of a cross-*sensitivity* reaction to Fulvicin *does exist.*

Supply: Fulvicin Tablets, scored, 500 mg., in bottles of 20 and 100; in 250 mg. in bottles of 30, 100 and 500. By Schering Corporation, Bloomfield, N. J.

Edward Tornow

Dr. Edward Tornow was born in September, 1911, in New York, and died on August 23rd, 1961 in Los Angeles. He received his preliminary schooling in Jersey City, New Jersey, and was a graduate of the Illinois College of Podiatry and Foot Surgery, with the class of 1937.

Upon his death, he was Vice President of the Southern Division of the California Podiatry Association; State Public Relations Director; a Fellow in the American College of Foot Surgeons; Chief of Staff of the Podiatry Clinic at Cedars of Lebanon Hospital, of which he had been a member for 17 years; Lecturer on hospital procedures and treatment of diabetic podiatry patients, and on rehabilitation for geriatric patients; and a member of Actors Equity.

Dr. Tornow started the Hall of Science in the State of California and was awarded 1st and 2nd prizes in 1959. He was the author of many articles on podiatry that appeared in the Journal of the A.M.A., the Journal of the A.P.A., American Druggist Journal, and the Nurses Journal. He had been Chairman of the Audio-Visual Committee of the California Podiatry Association, and had been a delegate and alternate to the American Podiatry Association House of Delegates. He also held a teachers credential in adult education for both first aid and drama.

Dr. Tornow was in Las Vegas making preliminary arrangements for the 1962 Region 12 meeting when he suffered a heart attack. He succumbed a week later after being moved to a hospital in Los Angeles.

He is survived by his wife, Hannah, and daughter, Guy.

Digests From The Literature

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

Anatomy

Variations in the Second Metatarsal Bone in Man, Bhargava, K. N., and Malaviya, G. Indian J. Med. Sci. 15: 100-105, 1961.

The second metatarsal, lying in the central axis of the foot, has its base mortised between the medial and lateral cuneiform bones posteriorly and the first and third metatarsals anteriorly. The many variations in its articular facets are seldom described. One hundred second metatarsals were studied from a collection of dried bones and dissected cadavers.

Among the variations noted were:

1. Variations in respect to the basal articular surface for the intermediate cuneiform bone. The promixal surface of the base articulating with the intermediate cuneiform bone was triangular in shape—an equilateral triangle in 12 cases, isosceles triangle in 55 (on the lateral side in 27 cases and on both sides in 28) an isosceles in 31 with a convexity on the medial side, and 2 with all sides of the triangle unequal, and with irregular margins on the lateral and medial sides.

2. Variations in respect to the articular facets on the medial side of the base—the small facet for the medial cuneiform, which is always present in normal cases, was absent in 7 specimens and insignificant in 22. In the remaining 71 it was prominent, but in one-third was directed forward, and the remainder directed downward and forward.

3. Variations on the lateral side of the base, which normally presents a dorsal and a plantar articular facet separated by a shallow groove and each facet subdivided by a vertical ridge, had four types of deviations: the plantar facet was undivided (38), or the dorsal facet undivided (2), or neither facet divided (6); or the groove between the two facets was bridged by extension of the articular areas (10 cases). There were even four different patterns of this bridge formation.

4. Many variations were noted in the site and number of the nutrient foramina situated in the middle of the lateral surface of the shaft. In 3 instances two nutrient foramina were present, and none in 5 others; the remainder (92) had a single foramen. The site of the single nutrient was on the lateral (61), or medial (21) or dorsal (10) surface of the shaft. Also, 47 were in the middle third of the shaft, and the rest in the distal third, except for 4 at the proximal third.

5. Variations existed also in the shaft, being normal in shape in only 62, with reduction in the dorsal surface in the others.

6. Variations in the region of the head were present in only 6 specimens, and of little significance; the articular surface was extended more on the plantar aspect than on the dorsal.

Extra Centre Ossification for the Medial Malleolus in Children, Powell, H. D. W. J. Bone & Joint Surg. 43-B: 107-13, 1961.

Two boys complaining of ankle pain were found to have centers of separate ossification for the medial malleolus—bilaterally, although the pain occurred unilaterally in one patient. The first boy received an injection of 25 mg. hydrocortisone acetate at the site of tenderness; 2 weeks later pain and tenderness were gone. Radiographs 5 months later showed that the extra center in both of his ankles was becoming incorporated in the normal lower tibial epiphyses. The second boy, with aching in both ankles, had a slight swelling on the inner side of the

right ankle. Radiographs showed a separate center of ossification for each medial malleolus, and a separate center at the tip of the right lateral malleolus. Examination 6 months later showed the ankles symptomless, and normal medial malleoli of more adult appearance, with no ossification centers now visible. However, the separate center for the right lateral malleolus was still present.

A series of 100 children, aged 6 to 12 years, without known disease or injury of either ankle, were studied radiologically; 20 showed extra centers—13 bilateral, 7 unilateral. When 50 adults, also without known injury or disease of either ankle, were examined radiologically, 4 showed separate ossicles—bilateral in only one subject. Since this variant occurs in a substantial proportion of normal children aged 6 to 12, and in a much smaller percentage in adults, it seems that most of the extra centers fuse in the normal malleolus during adolescence. Occasionally such centers remain separate throughout life. When an adult in whom this has occurred has been injured, this abnormality may be misinterpreted as evidence of a previous unrecognized injury at that site, and could bring medicolegal implications.

Circulatory Diseases

A New Treatment for Nocturnal Leg Cramps, Perchuk, E., Weinreb, M., and Asku, A. Angiology 12: 102-84, 1961.

Noctural leg cramps occur mostly in older persons, in cardiac patients, and in women during the last months of pregnancy. They may be the presenting symptom in patients with arteritis obliterans, deep thrombophlebitis, varicose veins, osteoarthritis, and static deformities. The pain is considered due to intense contractions of muscle fibers.

Methocarbamol (Robaxin®) was successfully administered to 24 patients; results were excellent in 19 and satisfactory in 5. Tablets containing 500 mg. of methocarbamol were administered, three tablets at bedtime (1500 mg.), or one tablet four times a day, or two tablets every 4 hours. The only side effect was a mild gastric intolerance in one patient, which was relieved by an antiacid. Cramps usually ceased in 72 hours after therapy began. The patients remained free of cramps for 3 to 4 weeks after discontinuing the drug.

The drug compares favorable with quinine, without the serious after effects of the latter. Methocarbamol seems to suppress reflex skeletal muscle spasm at the level of the spinal cord, thereby blocking proprioceptive stimuli arising from ischemic conditions, imbalance in metabolism, and calcium-phosphorus imbalance, before they are able to trigger clonic or tonic contractures. In this group of patients, mostly aged 40 to 80 years, the underlying causes were thrombophlebitis and other vascular disorders, pregnancy, profound diuresis after administration of Mercuhydrin, and miscellaneous disorders.

Leg Ulcers in Rheumatoid Arthritis, Beninson, J., and Ensign, D. C. J.A.M.A. 175: 437-40, 1961.

Use of pressure-gradient therapy, a high-protein diet, and wearing of suitable shoes, together with moderate walking exercise, provided successful results in leg ulcerations in nine arthritic patients. These patients had rheumatoid arthritis, psoriatic arthritis, or rheumatoid-like arthritis associated with lupus erythematosus. Pain from the ulceration was entirely eliminated by application of pressure-gradient dressings.

Three grades of ulceration were treated: (1) Minimal ulceration (up to one-eighth of an inch in depth), which healed in 3 to 6 weeks after application of the dressing and rest in bed, or in 4 to 6 weeks if the patient was ambulatory. (2) Moderate ulceration (one-eighth to one-quarter inch in depth) in which pressure-gradient dressing and bed rest produced healing in 4 weeks, or if curtailed activity was allowed, healed in 3 to 6 more weeks, or in 8 to 12 weeks in ambulatory patients. (3) Severe ulceration (one-fourth inch or more in depth) in which

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healing varied from 3 months under ideal circumstances, to over 1 year when ulceration was much deeper.

Poor healing occurring in arthritic patients may be due to the usually associated anemia and a protein-poor diet. When a high protein diet is enforced, healing is more rapid.

While the pressure-gradient booting is being worn and the ulcer is healing, measurements are made for pressure-gradient support. These supports are substituted for the booting as soon as healing takes place. Should pes planus develop, the patient should wear a comfortable shoe with a soft upper, and standard metatarsal bars attached to the outside of the shoe. The patient moves about for 5 minutes of each 30 minutes during waking hours. While sitting, the feet are not elevated, but are extended in front of the body, so that the support will not wrinkle and become uncomfortable.

A wheel chair equipped with a foot-exercising device is prescribed for a patient with ankylosed knee joints. The patient wears the pressure-gradient support, and operates the foot exerciser as though walking, for 5 minutes in each 30 minutes, to prevent lymphedema.

The technic described must be performed by a skilled operator.

Dermatology

New Drugs and Developments in Therapeutics, Council on Drugs' Digest. J.A.M.A. 176: 594-95, 1961.

Griseofulvin, fungistatic rather than fungicidal, the first drug used systemically with success in treatment of superficial fungus infections of the nails and feet, has a narrow spectrum and is limited to species of *Microsporum, Trichophyton,* and *Epidermophyton.* It should not be used until the causative agent is identified and known to be sensitive to this agent.

Itching is allayed within a few days and erythema and scaling subside within two weeks. Although the most effective drug in therapy of fungus infection of the nails (tinea unguium, onychomycosis), in some cases a plateau is reached after early improvement and no further progress is made. Complete eradication requires 4 to 5 months in fingernails and 6 months or more in toenails. Supposedly, griseofulvin is deposited in the keratin precursor cells, so that as keratin is formed, the drug remaining in the cells makes the keratin fungal-resistant; the new growth is free of disease and keratin containing fungi is exfoliated and replaced by normal tissue.

Minor side effects of the drug, such as headache, are common and sometimes severe, but usually end in 1 to 2 weeks, while treatment is continued. Serious side effects are uncommon. Occasionally maculopapular, vesicular, petechial and urticarial skin eruptions and overgrowth of Candida albicans have been reported. In a few cases epigastric pain, nausea and diarrhea may follow use of griseofulvin, and even reactivation of a long-standing colitis, and mental confusion. Fever, joint pain, lymphadenopathy, swelling of the hands and feet—resembling serum sickness—have been reported. Leukopenia has occurred. Periodic cell counts during griseofulvin is therefore advisable.

Although griseofulvin, like penicillin, is derived from *Penicillium,* no evidence has been found that sensitivity to one of these antibiotics implies senstivity to the other.

Griseofulvin: Low Dosage in Treatment of Dermatophytosis, Wechsler, R. L. Pennsylvania Med. J. 64: 364-66, 1961.

A group of 13 adults received small doses of griseofulvin for approximately one year, in treatment of fungus infection of the trunk, fingers, and feet—fingernails in 2, toenails in 2, and infections of hands, feet and nails in 9; all had existed for a number of years. Trichophyton rubrum was cultured from the toenails and skin of 12 and Trichophyton gypseum from toenails in one patient.

Two patients with fungus infection of the skin, who received 250 to 375 mg. griseo-

fulvin daily, improved after 6 months of therapy. Toe webs always were cleared last. These patients continued treatment for 8 to 9 months with this dosage; scaling occurred intermittently. The dosage was increased to 750 or 1,000 mg. daily for 3 more months. Scaling ceased in one patient, but occurred occasionally in the other patient. Scaling recurred in both patients when treatment was stopped. Skin infections responded similarly in 9 patients who had infected nails also. Three patients with fungus infection of the nails seemed cured after 4 to 5 months of treatment with 250 mg. daily, but one of these patients 3 months after discontinuing griseofulvin therapy had recurrence in the nails and skin of both the hands and feet, which responded to 5 additional months of treatment with 250 mg. daily. This patient is being maintained on that dosage.

Eleven of the 13 patients have been followed for approximately one year. Four were cured in 4 months and stopped treatment. All patients improved except one having all toenails and the skin involved; 1,000 mg. griseofulvin daily brought little change. Six of the 11 patients increased the dosage from 250 to 375 mg. a day to 500 to 1,000 mg. daily, and showed improvement, but the nails and skin of 4 patients continued to show some fungus infection. Patients on maintenance doses of 250 to 375 mg. daily continued to show control or improvement of the infection. All patients reported that excessive dryness of skin and pruritus disappeared in 3 to 4 weeks. Considerable time elapses before a normal nail grows out completely and before nail infection clears. The two patients who did best on small doses had almost complete self-evulsion or destruction of the nail caused by the infection. The suggestion is made that debridement of the nail may be a helpful adjunct in treatment of onychomycoses with low doses of griseofulvin. Although high doses bring improvement more speedily, the rate of cures is not increased. The dosage suggested is 750 to 1,000 mg. daily for 4 weeks of griseofulvin, and a maintenance dose afterward of 375 mg. every day.

Diabetes

Diabetic Neurotrophic Ulcers of the Feet: Surgical Correction by Wedge or Pie-Resection, McCullough, C. C., Jr. Missouri Med. 58: 117-18, 1961.

Amputation of the foot or leg, or prolonged plastic procedures, are not always necessary in this disorder The lesions have been found to respond well to a limited excision of the area. Topical therapy is of no avail in these cases. Cross leg flaps are unsuitable, because of the long bed rest required by plaster immobilization of both legs. With use of wedge resection, healing takes place with delay, even though the resection was done in an area of neurotrophic anesthesia. The principle is removal of the underlying mechanical cause of the skin breakdown in that particular area.

The head of the metatarsal underlying the ulcer is resected, along with the necrotic tissue present. It is more satisfactory to resect the toe and metatarsal in its distal two-thirds, since the toe if left may be involved by bacterial invasion and neurotrophic changes. The wound is closed with one or two sutures of silk or nylon, without subcutaneous sutures and the usual absorbable skin closure. Skin sutures are removed in about two weeks. Coaptation of the two parts of the foot is accomplished during and after closure and the closure maintained by application of an elastic band dressing.

Four cases, all with plantar ulcers, are reported, demonstrating the feasibility of limited excision. In one patient, with diabetes for 25 years, because of severe neuropathy, it was not necessary to use an anesthetic; he felt no discomfort during the operative procedure. Satisfactory weight bearing was attained in about three weeks. Crutches were used for a few days. The lesions heal rather promptly, and the areas do not tend to break down.

Organization News

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

District of Columbia

The District of Columbia Podiatry Society, at its October 1961 meeting, approved a $50 donation to each of the accredited podiatry schools for the purpose of starting an interest-free loan fund for the use of needy students, as advocated in the Selden report. The motion included a challenge to the societies of the 50 states and Canadian Provinces to follow this lead and match this donation.

At a cost of $250, each state association can begin to attract more and better students. If all states and provinces accept this challenge, a fund upward of $2,500 per school will be raised. This should be sufficient to start an adequate loan fund.

When the new school in Philadelphia is ready to accept students, undergraduate or graduate, they will also share in this grant.

The D. C. Podiatry Society is sponsoring the annual ten-mile run, called the Bunion Derby, at the National AAU Convention to be held on December 2, 1961 in Washington, D. C.

A contribution of $200 has been made by the D. C. Podiatry Society to support the scholarship program of the District of Columbia Society for Crippled Children. The program will permit selected technicians to receive instruction at the Whitley Rehabilitation Training Center in Greenwich, Connecticut, which is supported by the American Montessori Society.

Minnesota

The annual meeting of the Minnesota Podiatry Association was held in the lake and sporting country of Brainerd, Minnesota. Dr. Clarence Aho was host. Dr. Philip Brachman conducted a 2-day lecture. Those attending spent half of each day enjoying the many recreation facilities.

The following officers were elected: Presi-

"LIFE'S FOUNDATION — YOUR BABY'S FEET" is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Podiatrists-Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

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dent, Ernest Ueland; President Elect, Robert Ray; 1st Vice President, Joe Thul; 2nd Vice President Conrad Meints; Secretary-Treasurer, Edward Tarara; A. P. A. Delegate, Palmer Goulson and Region 6 Delegate, Willard Olson.

Minnesota again participated in the educational program at the State Fair. Forty podiatrists and ten auxiliary women conducted the annual childrens' foot posture examination. More than 1,600 children with their parents took advantage of this service. The MPA was commended highly by the State Fair Administration for this free educational program.

New Hampshire

Members of the New Hampshire Podiatry Association met at the home of Richard Descoteaux, Manchester, N. H., President. Guest speaker, George D. Krasner, M.D., Chief of Radiology Department, V. A. Hospital, gave an excellent review, concluding with a question and answer session. Following the scientific program, luncheon was served.

Pennsylvania

Northwestern Division

The Northwestern Division of the Pennsylvania Podiatry Association met on Sunday, September 10, at the Elk's Club in New Castle. Fifty-two members and guests were present. President Richard Wagner introduced Drs. Ralph W. Dye and Clarence Larson of Erie County Division, both charter members of the Northwestern Division. Drs. Chester Rossi and Quinton Crawford gave a report on the House of Delegates meeting in Philadelphia. Dr. John Petrus of Erie county Division and President-elect of the state society, gave a report on state and national affairs. Dr. Ralph Orr gave a very interesting and informative talk on "Diagnosis" and showed color slides of actual cases taken in his office.

Following the meeting a social hour for members, wives and guests was held at Shady Haven, the home of Dr. and Mrs. J. D. Fletcher.

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Tennessee

Memphis

At the September meeting of the Memphis Chiropody Association the following were elected to office: President, Stephen A. Lamm; Vice President, Robert H. Gold, and Secretary-Treasurer, Donald R. Skwor.

The series of 50 slides, purchased by the group from the Audio-Visual Council of the parent organization, has been well received by public groups when shown as an illustrated lecture.

Washington

The Region 7 Convention will be held in conjunction with Seattle's World Fair "Century 21" on May 4, 5 and 6. Chairman Salter announced that Dr. Lester Walsh will be the principal speaker.

Six podiatry regional directors for Civil Defense were announced by state President Routh. These directors will work with Drs. Watters and Armstrong, who are on the "State Steering Committee" of medical and paramedical professions for Civil Defense. Several podiatrists are taking the "Instructors Course" in Red Cross Basic First Aid for teaching, and all podiatrists have been urged to renew their basic First Aid course as recommended by the A.P.A.

Decision was made to retain a qualified editorial writer of the "Washington State Labor News" newspaper to represent the podiatry profession in labor circles and to write regular articles in that widely read paper. It is felt that this action will enhance our position for securing the desired medical insurance legislation during the next State Congressional sessions.

A.C.F.O.

The Tenth Anniversary of the American College of Foot Orthopedists was observed at its recent annual dinner, held in Miami, Florida. Officers elected were as follows: President, Jack Stern, Chicago, Illinois; President-elect, Herman L. Siegler, Levittown, L. I., New York; Vice President, Joy E. Adams, St. Petersburg, Florida; Vice President, Joseph R. Cinzio, Passaic, New Jersey; Secretary, Robert R. Jacobs, Thiensville, Wisconsin; Treasurer, D. A. Goodwin, Marion, Ohio; Trustees, L. B. Thompson, Kenosha, Wisconsin, Morris Haas, Albuquerque, New Mexico and Arthur Helfand, Philadelphia, Pennsylvania.

A plaque was presented to Retiring Presi-

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dent Murray Bromberg for his outstanding service to A.C.F.O. Drs. L. B. Thompson and Herman L. Siegler received keys, attesting to their excellent work during the years 1960-61.

Third Annual Golf Tournament

The third annual A. P. A. National Golf Tournament was held in connection with the Annual Meeting, August 1961, at the Westview Country Club, Miami, Florida. Contestants included 25 men and 3 women. Co-Chairmen of the Golf Committee were Drs. D. Alexander of Cicero, Illinois and M. Kleimann of Miami, Florida.

Awarded trophies were the following: Dr. C. Leydecker, St. Louis, Missouri, won the roving trophy for Low Gross Score with an 83; First place in Division A was won by Dr. R. Wysocki, Toledo, Ohio and Drs. A. Ruday and H. Larsen tied for Second place in this division; First place in Division B, Dr. Robert Roberts, Findlay, Ohio, and Second place to Dr. J. Tredway, Seattle, Washington; First place, Division C, Dr. Edward Ganny, Washington, D. C. and Second place, Dr. F. Gamble, Tucson, Arizona. Since there was only one entrant in Division D, First place was won by Mark Rappaport, a student at Ohio College.

In the Women' Division, Mrs. Jean Nyman won First place and Mrs. Romaine Gamble, second place. Trophies were awarded at the Inaugural Ball on Monday night, August , 1961.

Special prizes awarded were: Men's Longest Drives, Wyatt Cox, Ohio College student, 260 yards; Women's Longest Drive, Mrs. D. Potter, Ft. Bragg, North Carolina, 180 yards; Closest to Pin, Dr. B. Niswonger, Jackson, Tennessee, 20 feet, 5 inches.

Appointment

Dr. Richard A. Cole was recently appointed to Commander in the Podiatry Section of the Medical Service Corps, United States Naval Reserve. In preparation for selection, Dr. Cole completed several professional courses of study under the Naval Reserve program, including Aviation Medi-

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References:
1. McGavack, T. H.; Wiener, D.; Bell, M.; and Boyd, L. J.: Archives Dermatology and Syphilology **59**, 94 (1949).
2. Rankin, J. L.; Dobes, W. L.; Jones, J. W.; and Alden, H. S.: Southern Medical Journal **44**, 616 (1951).
3. Gordon, M. A.: Archives Dermatology and Syphilology **66**, 573 (1952).
4. Moore, M.: Archives Dermatology and Syphilology **66**, 621 (1952).
5. Teichmann, W. O., and Horwath, P. N.: Southern Medical Journal **50**, 1521 (1957).
6. Hoffman, H. L. (Washington, D. C.): Personal communication.

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cine, Submarine Medicine Practice, Combat and Field Medicine Practice, Manual of the Medical Department-1, Medical Department Orientation, and Control of Communicable Diseases in Man.

Commander Cole is attached to Medical Specialist Company 5-6, Washington, D. C. He is a member of the District of Columbia Podiatry Society, and the American Association; past president of the Military Association of Podiatrists and past president of the Board of Podiatry Examiners in the District of Columbia.

A.A.P.P.

Newly elected officers and Board of Directors of the American Academy of Psychosomatic Podiatry for the coming year are as follows: President, George C. Custer, Chicago, Illinois; President-elect, M. C. Nuddleman, Oakland, California; Past President, Jack T. Sanders, Albany, California; Vice President, Earl Sheff, Charleston, West Virginia; Secretary-Treasurer, Myron Simon, Anaheim, California.

Dr. Custer spoke at the 49th Annual Meeting of the A. P. A. in Miami Beach, Florida. Many podiatrists expressed interest in this group and any questions may be addressed to the secretary.

National Board of Chiropody

The National Board of Chiropody Examiners will conduct a 4-day examination in recognized colleges. Part I will be given on March 26 and 27, 1962, and Part II on March 28 and 29, 1962. The fee will be $25 for each part.

If you are a graduate of a recognized college, you will be able to take this examination. If you are now practicing or have practiced, you must present evidence of professional and moral fitness from your local and state society; also from the secretary of the board of examiners of your state in which you practice or have practiced.

The state boards that will recognize the National Board examination as their written examination are as follows: Arkansas, Hawaii, Idaho, Illinois, Iowa, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Pennsylvania, South Carolina, South Dakota, Wyoming, British Columbia, and Ontario. Other boards are now contemplating the recognition of the National Board examination.

If you wish to receive the 8-page booklet regarding the National Board examination and an application, contact the dean of any one of the five colleges or Dr. L. A. Hansen, 800 Professional Building, Kansas City, Missouri. The fee and application must be received 30 days prior to the examination date.

Appointments to Test Committees

The National Board announces the appointment of two more members to its test committees. They are as follows: Bacteriology — Manuel B. Rodriguez, M.D., Ohio College, Cleveland, Ohio; Pathology — William Hoffman, M.D., Ohio College, Cleveland, Ohio.

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Federation Meeting

At the 26th Annual Meeting of the Federation in Miami, Florida, the following officers were elected: President-elect, Francis Schwarz, Troy, New York; First Vice President, Julius Citron, Phoenix, Arizona; Second Vice President, H. A. McAninch, Spartanburg, South Carolina; Third Vice President, R. E. Tanner, Indianapolis, Indiana; Secretary-Treasurer, L. A. Hansen, Kansas City, Missouri; A. G. Kalin assumed the office of President for the ensuing year. M. K. Upshaw is the retiring President.

National Board Meeting

The National Board held its 6th Annual Meeting in Miami, Florida. The following officers were elected: President, M. H. Gennis, Tulsa, Oklahoma; President-elect, Robert Stess, Perth Amboy, New Jersey; Vice-President, Samuel Brezak, Brooklyn, New York; Secretary-Treasurer, L. A. Hansen, Kansas City, Missouri; Executive Committee, LeRoy Numbers, Chicago, Illinois and Edward Tarara, Rochester, Minnesota. Pierce Nelson is retiring President.

Communication from the Profession

To the Editor:

I have just finished perusing the report of the "Selden Commission" on podiatry education for the '60's. It is a masterful, clear, concise and accurate appraisal of our educational picture, performed by qualified and disinterested parties who are experts. Apparently there are some members of our organization who feel a frank, honest appraisal of our educational status would be in order—to the extent of authorizing the expenditure of moneys and time to come up with some answers and recommendations.

For a long time I, as well as a small segment of our profession, have felt that there were some vast inadequacies in the educational training of our profession.

At the outset I most heartily concur with the Selden Commission recommendation that there be an agreed upon, universal definition of our profession and scope of practice. In reviewing the past, I believe

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there have been entirely too many different definitions of podiatry (chiropody), depending upon geographical location, state licensure limitations and individual practitioners. The first definition, which was somewhat proscribed by the Council of the A.M.A., was that we were a handmaiden ancillary to medicine, filling a void that was neglected by medicine. This, in simple terms, implied that we would care for lesions that medicine was too proud, or felt were too insignificant to care for. Essentially that meant superficial excrescences, minor ingrown toenails, appliances and basic physiotherapy. That definition restricted the maneuverability and scope of practice, but was accepted by the vast majority of the profession and they were happy with the definition.

As educational standards and requirements increased, there were certain requests for increased scope of practice. In certain areas these were granted: i.e., X-ray, narcotics, antibiotics, surgery, diagnostic tests, internal antiseptics and analgesics, etc.—in a great many instances, not without a great amount of struggle from other professions and even our own profession.

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Now to get back to the crux of our definition problem. From my humble observation, there apparently are several approaches. I believe that the above stated definition is accepted by the majority of practitioners, other professions, and the public. I have been somewhat of an idealist, and I believe that there is an increasingly large segment of our profession that would like to see that definition enlarged, based upon the foundation of adequate educational background and clinical training, to ultimately be defined as *Medicine and Surgery of the Foot.*

In the problem of definition of terms, we are faced with the prior definition of "Profession." The term profession, as distinguished from trade or business, entails education, training, licensure and above all, responsibility. If we envision ourselves as a profession, we will then have to ultimately assume full responsibility for that organ called the "foot." Therefore, we will eventually have to be physicians and surgeons of the foot, with the finest educational and clinical training for that responsibility.

I know that there are a great number of members of our profession who earnestly feel that there is now, and will be in the future, a genuine need for a profession that will be competent and responsible for all diseases of the foot. I know Medicine would like to see that come about.

Ophthalmologists limit themselves to the eye, whereas in previous years, they included the ear, nose and throat (e.e.n.t., now usually e.n.t.). There is a possibility that there might emerge a profession, limiting

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itself to diseases of the foot, with an M.D. degree; 1 year of internship, 2 years of residency, as an orthopedist and 1 year limited to diseases of the foot. This is a possibility that may confront us from malcontent orthopedic surgeons who are recommending such a course for newer orthopedists. If that should happen, we would automatically be limited to the prior definition. I would not like to see that happen. It must not happen.

There is another segment of our profession that has taken the first definition and organized the chaos and administering of such a practice, with the addition of preventive podiatry, to a fine point wherein such a practice can be highly successful if efficiently operated on sound business principles, with practice management and control. This is another definition and a step in the development of our definition.

I subscribe to the ultimate, or ideal, as I believe a great many more in the profession are eventually accepting that podiatry in the '60's will be defined as Medicine and Surgery of the Foot.

In order to lay the proper foundation for such a definition, the report of the Selden Commission on the Education of Podiatry in the '60's is a firm base with its clear-cut recommendations for improving our educational plants, faculty, calibre of student, curriculum and clinical training. To implement their recommendations, I believe that we cannot proceed in many directions simultaneously. It goes without saying, that we cannot bring all of our schools and training programs up to acceptable standards for the recommended definition. We should decide on one school that most nearly approaches our minimum requirements, and then devote our entire financial effort to making that school acceptable. Then proceed to one school at a time.

I believe most strongly that we can achieve all of our goals, ideals and aspirations for our profession, if we concentrate on our educational plants, clinical training facilities, and hospital facilities to prepare ourselves for these responsibilities.

Willard W. Fine, D.S.C.
Columbus, Ohio

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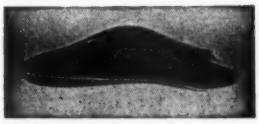

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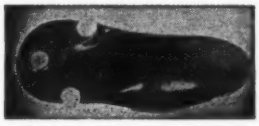

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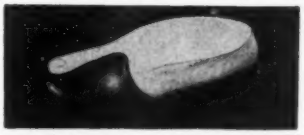

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Sometimes we can see more clearly when standing afar. Being here in Europe and looking at the differences of chiropody-podiatry in the Old Country, as contrasted to that of the United States, the progress of our profession stands out sharply.

The conditions of our professional person are of such greater elevation that one begins to wonder why the difference. The realization must come to all of us that our profession has made these great strides by fighting for them. Advancement can only come from within, and again it means that the stronger our National organization, the stronger will be our profession. A complete professional organization must have an active and strong Women's Auxiliary to help do jobs in public relations, as well as that of internal progress, such as aid to our schools. In this field, we in the Auxiliary are preparing to help the students by the Student Emergency Fund.

This is but a beginning in the aims of the Women's Auxiliary to assist the APA-NAC in furthering the advancement of the profession.

Mrs. Fred G. Broun, President

Legal and Legislative

Delaware

Changes were made in the Delaware Practice Act relating to fees for examinations, re-examinations and renewal of certificates. These fees were increased from $25 to $50; $2 to $25, and $3 to $10, respectively.

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Deaths Reported

Jacob P. Barbey
Brooklyn, N. Y.

Stanley B. Klein
Uniondale, L. I., N. Y.

Frank C. Nastrey
Bridgeport, Conn.

Dr. Nastrey died at the age of 68. He was a member of the county, state and national societies and had practiced in Bridgeport for 47 years.

Robert J. Smith
Passaic, N. J.

Chiropody student, Robert J. Smith, 22 years old, was found slain on the rear lawn of the John Hay High School in Cleveland, Ohio. He had been stabbed once in the chest. He was apparently stabbed as he walked home from his job at a drugstore. Mr. Smith was a sophomore at the Ohio College of Chiropody. He is survived by his mother, Mrs. Joseph Smith.

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Dates to Remember

EVENTS

Annual Foot Health Week
May 11-18, 1962

American Youth Foot Care Week
Oct. 15-20, 1962. Sponsored by American Foot Health Foundation.

MEETINGS

American Podiatry Association

Fiftieth Annual Meeting
Washington, D. C., Aug. 16-21, 1962
Shoreham Hotel
Seward P. Nyman, Convention Manager
3301 16th St., N.W., Washington 10, D. C.
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)

Region Two
(New York)
New York, N. Y., Feb. 23-25, 1962
Barbizon Plaza Hotel
Mr. Gilbert Hollander, Convention Mgr.
30 Central Park South, New York 19, N. Y.

Region Three
(Del., Md., N. J., Pa.)
Atlantic City, N. J., Apr. 26-29, 1962
Ambassador Hotel
Bernard C. Egerter, Gen. Chairman
909 Empire Bldg., Pittsburgh 22, Pa.

Region Four
(Ohio)
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

Region Five
(Ill., Ind., Mich., Wis.)
Midwest Podiatry Conference
Chicago, Ill., Mar. 16-18, 1962
Sheraton-Chicago Hotel
Dr. Earl G. Kaplan
14608 Gratiot Ave., Detroit 5, Mich.

Region Six
(Colo., Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Minneapolis, Minn., May 25-27, 1962
Hotel Raddisson
Dr. W. J. Olson
322 Midland Bldg., St. Paul, Minn.

Region Seven
(Idaho, Mont., Ore., Wash., Wyo.)

Region Eight
(D. C., N. C., S. C., Va., W. Va.)

Region Nine
(Florida)
Joy E. Adams
401 Florida Natl. Bank Bldg.
St. Petersburg, Fla.

Region Ten
(Ala., Ga., Ky., Miss., Tenn.)

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
Dallas, Texas, June 21-23, 1962
Sheraton Hotel
Mr. C. J. M. Roesch, Ex. Sec.
Chiropody Society of Texas
407 Austin Savings Bldg., Austin, Texas

Region Twelve
(Ariz., Cal., Nev., Utah)
Las Vegas, Nev., May 25-26, 1962
Flamingo Hotel
Dr. S. J. Hoffman, Chairman
585 S. Fairfax Ave., Los Angeles, Calif.

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THEN YOUR NATIONAL

Mood Elevators

Contributions to this column are more than welcome. In fact it depends upon them. A.O.P.

Open and Shut Cases

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And often put on airs.
Their open minds, I sometimes find
Need closing for repairs.

Question: To go to college or not.

He had honors and degrees but was a failure financially. His grade school classmate was making plenty as a merchant. The college man asked his "dumb" classmate how he did it. "Trouble with you college boys," was the answer, "all try to make 10 to 15 percent profit. Me, I buy for a dollar and sell for 3 dollars. Just 3 percent is all I try to make."

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DR. POD

"Honestly, Doctor, he is the hardest child on shoes!"

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Danger
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1. The names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, American Podiatry Association, 3301 16th St., N.W., Wash. 10, D. C. Editor, A. Rubin, D.S.C., 3301 16th St., N. W., Wash. 10, D.C.

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5. The average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the 12 months preceding the date shown above was: (This information is required by the act of June 11, 1960 to be included in all statements regardless of frequency of issue.) 5,700.

(Signed) A. Rubin, D.S.C., Editor

Sworn to and subscribed before me this 29th day of September, 1961.

(Signed) Ethel B. Schaefer
(My commission expires January 1, 1963)

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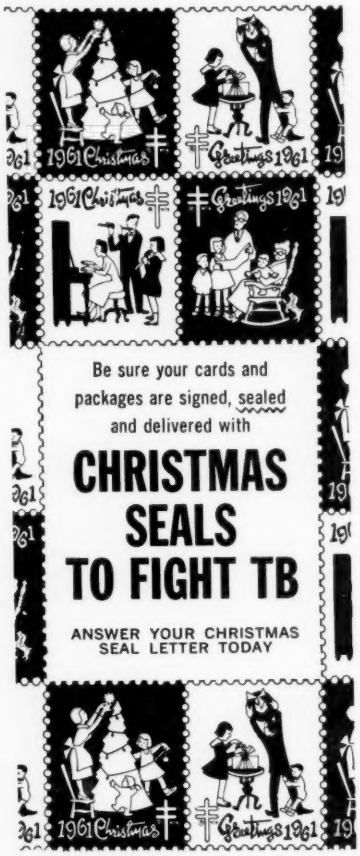

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